UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION — MDL No. 2804; Case No. 1:17-MD-2804

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THIS DOCUMENT RELATES TO ALL CASES — Hon. Dan A. Polster

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HIGHLY CONFIDENTIAL - SUBJECT TO FURTHER CONFIDENTIALITY REVIEW

VIDEOTAPED DEPOSITION OF
CURTIS WRIGHT, IV, M.D., M.P.H.

Wednesday, December 19th, 2018
9:01 a.m.

Held At:
Grappone Conference Center
70 Constitution Avenue
Concord, New Hampshire

REPORTED BY:
Maureen O'Connor Pollard, RMR, CLR, CSR

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VIDEOGRAPHER: David Kim

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E X H I B I T S

P R O C E E D I N G S

THE VIDEOGRAPHER: We are now on the record. My name is David Kim, I'm a videographer for Golkow Litigation Services.

Today's date is December 19th, 2018, and the time is 9:01 a.m.

This video deposition is being held in Concord, New Hampshire in the matter of National Prescription Opiate Litigation, MDL 2804, for the U.S. District Court for the Northern District of Ohio, Eastern Division.

The deponent is Curtis Wright.

Counsel will be noted on the stenographic record.

The court reporter is Maureen Pollard, and will now swear in the witness.

CURTIS WRIGHT, IV, M.D., M.P.H., having been duly sworn, was examined and testified as follows:

MR. SNAPP: May I make a statement on the record about the confidentiality protective order?

MS. SINGER: Of course.



MR. SNAPP: Thank you.

I just want to confirm that everyone on the phone and in person agrees to be bound by the confidentiality protective order in the MDL or the applicable state cases. If that is not the case, please speak up now.

Hearing nothing, please proceed. Thank you.

EXAMINATION

BY MS. SINGER:

Q. All right. Good morning, Dr. Wright. My name is Linda Singer, I'm an attorney for plaintiffs in the litigation.

Let me start by reminding you that you've been sworn in. You're here pursuant to a deposition notice, is that correct?

A. Yes, ma'am.

Q. I'm going to show you what we've marked -- we'll work out the kinks.

I'm going to show you what we're going to mark as Exhibit 1.

(Whereupon, Purdue-Wright-1 was marked for identification.)

BY MS. SINGER:

Q. Do you recognize -- and, Dr. Wright,

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do you recognize that notice?
A. I think so. It looks like the one I received by e-mail.
Q. Okay. And have you prepared for your testimony today with anybody?
A. Yes.
Q. And with whom did you prepare?
A. With my attorneys, and with two attorneys who I think represent Purdue.
Q. And is that your attorney seated next to you?
A. Yes.
Q. Okay. And do you recall who from Purdue you prepared with?
A. Erik and Marina.
Q. And about how much time did you spend preparing for today's testimony?
A. Several hours on four days.
Q. Okay. And you counted on your fingers, is that because it's less than ten or more than ten hours?
A. Just to try to be right.
Q. No, I appreciate that.
So do you recall roughly? You said a few hours?

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MR. SNAPP: Several, he said.
A. About 10 to 12 hours total.
BY MS. SINGER:
Q. Okay. Did you review any documents in preparing to be here today?
A. They presented me with a number of documents.
Q. Okay. And "they" being your counsel or Purdue's counsel?
A. Both, I think.
Q. Do you recall roughly how many documents you received?
A. No. A lot.
Q. Okay. And one of the things I'll tell you -- I know you've been deposed before, is that correct?
A. Yes, ma'am.
Q. Okay. So one thing I note that will be important is, first of all, if you don't understand a question, please let me know, I am happy to rephrase it or repeat it.
And second is please, other than just this moment, when you're answering please respond verbally so it will be reflected in the record.

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A. Yes, ma'am.
Q. Okay. All right. So you indicated -- I'm sorry.
Is there any reason that you can't testify truthfully or accurately today?
A. I know of no reason.
Q. Okay. And you said you've been deposed before, correct?
A. Yes, ma'am.
Q. How many times, if you recall?
A. I don't really remember. I don't -- because I'm not sure exactly what the difference is between deposition and other legal interviews.
Q. Okay.
A. Two or three.
Q. Okay. And how long has it been since you have testified in a deposition?
A. Many years. I don't know how many.
Q. Okay. Have you testified in any depositions in the last two years?
A. No, ma'am.
Q. What about at trial, have you ever testified at trial?
A. Yes.

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Q. And tell us about the context in which you testified at trial. What was the case?
A. That was a case involving disulfiram toxicity many years ago.
Q. Okay. And have you ever testified at trial in any case relating to opioids?
A. I don't remember any.
Q. Okay. Or in connection with your work at Purdue Pharma?
A. I don't think so, ma'am.
Q. And the depositions that you were a witness in, did those relate to opioids, or to other matters?
A. They related to opioids.
Q. And can you recall the details of any of those cases?
A. Only vaguely. One had something to do with an insurance company and Purdue and their insurance, I think. And I never really knew what the others were about.
Q. Okay. Do you recall if any of them were personal injury cases?
A. I don't think so.
Q. Okay. All right. Let's turn to your background. So can you describe briefly your

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medical training and background before joining the FDA?
A. Yes, ma'am. I got my bachelors from Haverford College. Worked at a chemist at the National Institutes of Mental Health. Went to night school, went to George Washington University, did a -- got my MD degree. Went -- I did a general rotating surgical internship at Naval Hospital Portsmouth, I had joined the Navy. Served in the Navy for ten years -- eight to ten years as a general medical officer. Went to Johns Hopkins University, did a masters in public health and an occupational medicine residency. Then did a postdoctoral fellowship in behavioral pharmacology of opioids. Then sat for and took the boards in clinical pharmacology. And I think that's it.
Q. Do you have any specialized training relating to addiction or addition medicine?
A. Yes. I was at one point an American Society of Addiction Medicine certified practitioner. And during my time in the Navy I served for two or three years as the medical officer for the tri-service alcoholism recovery facility that handled alcoholism and drug

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dependence.
Q. Okay. And any medical school training relating to addiction or fellowship or anything like that?
A. Just the NIDA fellowship at Behavioral Pharmacology Research Unit.
Q. And when did you join the Food and Drug Administration, or FDA?
A. I think it was 1989.
Q. And why did you move to the FDA? Makes you smile?
A. Well, my wife said that I either needed to get a paying job and stop going to school or we'd be moving into the park. I had three job opportunities at the time, and I applied, and I chose the FDA.
Q. And why, other than the paycheck and your wife?
A. It was more attractive than the other two. It looked more interesting.
Q. And what were your responsibilities in your first position at the FDA?
A. I started as a junior medical officer reviewing investigational new drug applications and -- investigational new drug applications and

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new drug applications.
Q. And how long did you do that for?
A. I'm not sure. At some point in there I was promoted to senior medical officer. I don't quite remember when. And I was also made head of the drug abuse staff in our review division.
Q. And how long were you at the FDA?
A. About eight to nine years.
Q. And what were generally your responsibilities over the course of your tenure?
A. Review of investigational new drug applications, applications to study new drugs. Peer review of reviews that had been done by other medical officers. Consultative services to other FDA departments related to drug abuse issues. On several occasion I was acting division director.
Q. For which division?
A. This was the -- had different names at different times. It started as the pilot drug evaluation staff, it was then HFD-170 of the pilot drug evaluation division, then its name changed, and I can't remember what they changed it to. It may have changed again, but it was

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all the same group of people.
Q. Okay. And your role in that division covered the same responsibilities related to reviewing and assessing new drug applications?
A. Yes, ma'am.
Q. And while you were at the FDA prior to your involvement in OxyContin, were you involved in the review or approval of any other opioid drugs?
A. Yes, ma'am.
Q. Which drugs?
A. I can tell you the ones I remember. I'd have to look at a list to tell it. But I was involved with pretty much every opioid that came through the division, was involved with, and some NSAIDs. I was involved with Duragesic. I was involved with -- now, the ones I remember were just a mixed bag of opioid products, some military morphine, nasal morphine came in; several controlled-release opioids, I'd have to look up to remember which ones; one or two NSAIDs; some dosage form amendments. Just a large collection of opioid drugs.
Q. Do you remember roughly how many opioids you had reviewed prior to OxyContin's

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approval?
A. I would have to guess. I don't know.
Q. Okay. Count them on two hands, or do you need more than that?
A. If you count investigational new drug applications, it would have been five or six, I think.
Q. And when did you leave the FDA, what year?
A. I think it was 1997.
Q. And why did you leave?
A. I had been passed over for division director for the third or fourth time, and it was becoming clear to me that I would -- that I was -- it would be a long time before I was promoted or had any additional responsibilities, and an extremely attractive offer came in from a pharmaceutical firm to be their chief medical officer, and I accepted.
Q. And do you know why you were passed over for promotions at the FDA?
A. Do you want an answer for now or from then?
Q. What you know now.
A. I wasn't ready. I did not have the

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personnel management skills to be a division director.
Q. And were you told anything by others at FDA at the time you were passed over for these positions?
A. No.
Q. It just passed?
A. It just got turned down.
Q. All right. So you said you went to join -- you had a very attractive offer at a drug company. What drug company was that?
A. Adolor Pharmaceuticals.
Q. And what kind of product did Adolor make?
A. They were working on an extremely exciting product, it was a peripherally acting, non-centrally acting opioid, so it had the potential for giving analgesia without affecting the brain and without giving euphoria.
Q. Okay. And do you know, at the time you were at Adolor, were you aware if OxyContin had become commercially successful at that point?
A. No, ma'am.
Q. I'm sorry, it was a layered question.

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So were you not aware, or had it not become?
MR. PETRILLO: Objection to form.
A. I was occupied full-time with my new job, and I didn't -- I neither knew nor particularly cared.
BY MS. SINGER:
Q. And how long were you at Adolor?
A. A year to a year and a half.
Q. And why did you leave?
A. There was a mixture of reasons that I left Adolor. We had some discouraging information -- clinical trial results from our lead compound. I was living apart from my wife and commuting to see her on weekends, which was very exhausting. We had great difficulty finding a home in the Adolor area. And my wife told me that she had been contacted by a recruiter and I needed to think about other employment.
Q. So a certain through-line here.
And did you -- were you recreated to Purdue Pharma from Adolor?
A. Yes, ma'am.
Q. How did that response -- how did that

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opportunity come to you?
A. A recruiter from a recruitment company, I believe, I don't know whether he had a company or whether he was independent, contacted my home, and my wife talked to him. And she thought I should talk to him, and I didn't. And he called again, and she suggested very firmly that I talk to him. And I talked with him and met, we met with him. And he and she convinced me that I should interview at Purdue.
Q. And "she" is your wife, is that correct?
A. Yes, ma'am.
Q. And do you remember when this was?
A. Before -- all I remember is it was before I went to Purdue.
Q. And do you recall with whom at Purdue you met before joining the company?
A. Robert Reder.
Q. And had you had any conversations with Purdue prior to that time about joining Purdue Pharma?
A. No, ma'am.
Q. No conversations while you were at the

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FDA about moving to Purdue?
A. No, ma'am.
Q. All right. I'd like to show you Exhibit 2.
(Whereupon, Purdue-Wright-2 was marked for identification.)
MS. SINGER: This one we have enough copies of.
BY MS. SINGER:
Q. So, Dr. Wright, do you recognize Exhibit 2 titled "Curtis Wright IV, MD, MPH Curriculum Vitae"?
A. Yes, ma'am.
Q. Okay. I'm going to read the document number into the record. It's PPLPC013000116251.
And you recognize this as your curriculum vitae?
A. This is one version of my curriculum vitae.
Q. Did you prepare this version of your curriculum vitae?
A. I believe so.
Q. Okay. I'd like to direct you to Page 2, which is Bates number ending 52. And if you look about two-thirds of the way down the

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page, Executive Director, Medical Research, Purdue Pharma.
Do you see where I am?
A. Yes, ma'am.
Q. And does that refresh your recollection as to when you joined Purdue?
A. If I got it right, it was around 12/98.
Q. Do you have any reason to believe you got that wrong?
A. Only my general miserable problem with dates.
Q. Fair enough. I share that fault.
All right. Your first position at Purdue Pharma in 1998 or thereabouts was as executive director of medical research, is that correct?
A. Yes, ma'am.
Q. And what were your responsibilities as executive director for medical research?
A. From what I remember, or what I wrote?
Q. Why don't we start with what you remember.
A. Okay. I was given three new drug appli -- potential new drug applications, or

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projects to work on. I had a transdermal, a sustained-release opioid, and an opioid antagonist combination.
Q. So all three were opioid drugs, is that correct?
A. There's some dispute about how to call the transdermal, but yes.
Q. Okay. And beyond your responsibility for those three drug products, were there any other tasks associated with your position?
A. Early on, no. Very quickly I began to get questions from various people because of my expertise in drug abuse and my previous experience with the FDA.
Q. So it's fair to say that as with your position at the FDA, you also consulted with other people in the entity to give them your advice and opinions and experience?
A. When they asked.
Q. Okay. And to whom did you report as executive director of medical research?
A. Robert Reder.
Q. And did you have anyone who reported to you?
A. Yes.

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Q. Who was that?
A. It changed at various times because people came in. There was Serge Carpow, Bob Colucci, then Christopher Breder, then Dan Spyker, I'm moving forward in time, Douglas Kramer, Nab Dasgupta, and my eventually my secretary.
Q. That's okay. Don't worry, I won't put you on the spot.
So about how many people worked for you at any particular time?
A. Including the people that worked under those people?
Q. Yes.
A. Nine to twelve.
Q. And was Dr. Reader your supervisor for that entire period in that position? Did that change at all?
A. I'm unsure.
Q. You don't remember that it changed?
A. Well, it did change. Dr. Reder was replaced as head of medical -- of that -- whatever his title was by a Dr. Kramer.
Q. Different than the Dr. Kramer who worked for you?

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A. Yes, different Kramer. And then I was moved out of medical research in terms of reporting to report to Dr. Haddox.
Q. Okay. And did that change in your supervisor and the change in your position happen at roughly the same time, or were they separate events?
A. They were separate events.
Q. Okay. And was your next position once you moved as executive director of medical research and medical affairs, or is that kind of a continuation of the same job?
A. Well, it's really hard to say because I didn't move from one job to another and had a new job and new reports and new responsibilities. I carried one of the products all the way through until it was discontinued, carried another one about halfway and it was taken over by one of the new hires, and the third product ballooned into a multiple product product that I ended up being the medical officer for.
Q. Was that the naloxone project?
A. That was the Opioid X program.
Q. Okay. Which was the one -- of the

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three products, the one that involved naloxone, is that correct?
A. More than Naloxone, but yes.
Q. Okay. So you kept those three drugs even in this new position. Did you take on any additional responsibilities?
A. Yes, ma'am.
Q. And what were those?
A. I was the lead on the research unit that dealt with the -- I don't know how to describe it -- statistical understanding of OxyContin and other opioids' abuse and division.
Q. And did that division or department have a name?
A. I'm not sure what it was.
Q. Okay. And was this in your position in medical research and medical affairs, or was this a change that happened when you became executive director of risk assessment and health policy?
A. I would say it morphed into, from one into the other.
Q. Okay. So it was -- I don't want to put words into your mouth. It was an evolution rather than distinct jobs?

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A. I can't answer from a personnel perspective, because I did change who I reported to at one point. But in terms of my work, it gradually included more and more abuse and diversion issues and tamper-resistant opioid development issues, and I just carried the drugs along with that.
Q. Okay. And in this growing role with respect to OxyContin and drug abuse and tamper-resistance, that's the work in which you reported to Dr. Haddox, is that correct?
A. OxyContin wouldn't be correct to say there, because the Opioid X programs were many potential products other than OxyContin. But, and I'm not -- I'm not sure that reporting to Dr. Haddox on the Opioid X program was right because there was a team leader and a team for the Opioid X, and that was Brianne Weingarten.
Q. Okay. And was Brianne Weingarten between you and Dr. Haddox, or a separate line of reporting?
A. I would characterize it as a separate line of reporting.
Q. Okay. And so Dr. Haddox was your supervisor with respect to the drug abuse and

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assessment work that you talked about earlier, is that accurate?
MR. PETRILLO: Objection.
A. I don't know how to answer that, because I had a supervisor on paper, but Dr. Haddox sometimes acted as my supervisor, sometimes as my peer, and he was not supervisory in the same way that Dr. Reder had been.
BY MS. SINGER:
Q. And in what way was Dr. Haddox's supervision different?
A. He left the management issues pertaining to the Opioid X program to Brianne.
Q. Okay. And so during this period we're talking about with Opioid X and the drug abuse related responsibilities, was your title executive director of risk assessment and health policy?
A. I don't remember what my exact title was.
Q. Okay. And are we talking about the time period from 2004 until you left Purdue?
MR. PETRILLO: Objection.
A. I'm not good with dates, and this process took place from the time that I came to

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Purdue until the time that I left Purdue.
BY MS. SINGER:
Q. Okay. And do you remember when you left Purdue?
A. I believe it was 2005.
Q. Okay. We may come back to that one.
You mentioned the three products that you worked on over the course of your tenure at Purdue. Did any of those products precede to an NDA submission to the FDA?
A. One of them did, I think.
Q. And NDA, just to make sure we're on the same page, is a new drug application?
A. A new drug application was filed for after I left the company, or must have been filed, I wasn't there, so I don't -- but it couldn't have -- I believe that one of the products came to the market.
Q. Okay. And which one was that?
A. Transdermal buprenorphine patch.
Q. Okay. And would that have been Butrans, do you know?
A. I don't know the brand name, so I'm not -- I can't be positive, but I think that sounds right.

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Q. Okay. And what happened with the other two drugs? We can put Opioid X aside as I know that is a longer story, but what about the second drug?
MR. SNAPP: Object to the form.
A. The other drug was called Palladone, and that development program was terminated.
BY MS. SINGER:
Q. And why was it terminated?
A. It was terminated as a management decision, and I don't know exactly why. I do know that there were some technical problems with the formulation that were discovered very late in development.
Q. And do you recall what those technical problems were?
A. I can't say that they were the technical problems that caused the discontinuation, but it was vulnerable to alcohol, and if someone had been drinking alcohol before taking their pill the controlled-release properties could be distorted.
Q. Okay. And when you joined Purdue -- and I'm sorry, so we've talked about the three

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drugs, one we've put aside. Is there any other drug whose development you were involved in at Purdue?
A. Excluding Opioid X?
Q. Yes.
A. Well, the ones I remember are the HXA program, the transdermal buprenorphine program, and Palladone. Everything else I remember was involved with Opioid X.
Q. Okay. And the HXA product was what?
A. That was an early conceptualization of a hydrocodone/naloxone combination.
Q. What happened with that product?
A. It was sucked up into Opioid X.
Q. When you joined Purdue its principle products were opioids, is that correct?
MR. SNAPP: Object to the form.
A. The product that I knew about most was MS Contin, but Purdue had other products, but I was not involved with them.
Q. Is it fair to say that most of Purdue's sales or revenue were related to opioids, if you know?
MR. SNAPP: Object to the form.
A. I don't know.

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BY MS. SINGER:
Q. All right. I'd like to turn back to Exhibit 2, your CV. So looking at the middle item, "Medical Research/Medical Affairs." Do you see where I am in the middle of Bates number 52?
A. Mm-hmm.
Q. Let me make sure I'm in the right place. So can you read aloud the first paragraph under that item, "First executive director"?
A. Starting with "Responsible"?
Q. "The first executive director of a newly created position."
A. "The first executive director of a newly created position to rapidly and proactively address and retard the urgent and growing situation of abuse of the corporation's largest selling prescription opioid analgesic."
Q. Does that accurately describe your duties in medical research and medical affairs?
A. It's a little grander than I actually was.
Q. In what way?
A. The actions that were -- my duties

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dealt mostly with the scientific and medical side of addressing abuse and diversion. Dr. Haddox, Dr. Schnoll, another person whose name I've forgotten, dealt with the medical practice side.

Q. And by "medical practice," you mean the practice of prescribers of the product, is that correct?

A. Yes, ma'am.

Q. Okay. And is it accurate to say that you were the first executive director, and that it was a newly created position?

A. I think so.

Q. And in scaling this back to something, the not so grand and more accurate, did you have any responsibility for managing how Purdue's opioids were marketed?

A. No, ma'am.

Q. Did you have any responsibility or authority with respect to where Purdue's opioids were sold?

A. No, ma'am.

Q. Or how sales representatives were compensated?

A. No, ma'am.

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Q. And you were not involved, I think as you just said, in how prescribers were educated on using Purdue's opioids, is that correct?

A. I don't know if I was ever asked, and if I was asked I would have given my opinion, but I had no authority over the marketing of Purdue's products.

Q. And returning to your product development work, did any of the products you worked on have any relationship to addressing the 12-hour duration, or something called end of dose failure of OxyContin?

A. Not that I remember.

Q. And did any of them address something we'll talk about later, but I think that you described as the pharmacokinetic curve of OxyContin?

MR. SNAPP: Object to the form.

A. I'm unclear what your real question is.

BY MS. SINGER:

Q. So did any of the new drugs you developed seek to address the pharmacokinetic curve or the -- metabolizing the processing of OxyContin?

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MR. SNAPP: Object to the form.

A. I don't know how to answer that, because one of the products was a once a day product using a different opioid. But I was not involved with, except as part of the Opioid X program, with any modifications of OxyContin.

BY MS. SINGER:

Q. Okay. All right. Returning to Exhibit 2, your CV, the third paragraph under that same section on medical research and medical affairs, the last sentence, "This role included providing medical affairs" -- do you see where I'm reading, Dr. Wright?

A. Mm-hmm.

Q. Can you read that sentence?

A. "This role included providing Medical Affairs direction and support in the development of non-branded education and focus group topics and concepts regarding reduced abuse liability opioids."

Q. And can you -- does that accurately reflect one of your responsibilities?

A. I think so. I provided direction with respect to medical affairs, but I had no power.

Q. You don't what?

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A. I didn't have any authority.

Q. Tell me what you mean by that.

A. And I'm not sure medical affairs is the right word. I provided extensive opinion when asked about how to address abuse and diversion issues. I was asked on several occasions how to deal with issues pertaining to bad prescribers or bad pharmacies, and I provided the best answers I could.

Q. And who were you asked by?

A. I don't remember. There were multiple inquiries that would come in over time, I'd be doing my regular work and then someone would ask something, and I would answer.

Q. So -- and I may be reading something into your comments, but there seems to be something undertone that you offered opinions but they weren't taken. Is that true, or unfair?

MR. SNAPP: Object to the form.

A. I was a voice. There were many voices. Some voices had more experience in dealing with physicians, Dr. Haddox for example. My voice carried a lot of weight with respect to formulations, pharmacology, new drug products.

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I don't think I carried as much weight with respect to marketing because I didn't have any experience in it.
BY MS. SINGER:
Q. But you did offer opinions on marketing and on prescribing practices, is that correct?
MR. SNAPP: Object to the form.
A. I wouldn't characterize it that way.
BY MS. SINGER:
Q. How would you characterize it?
A. When someone asked me a question with respect to abuse, diversion, addiction, I gave them my best opinion.
Q. And so although your voice didn't carry as much weight with respect to prescribers, do you remember your opinion that you offered when asked on those issues?
MR. SNAPP: Object to the form.
A. I only remember specifically being asked when there was a question about what would help detail people identify potential problem prescribers, prescribers who were prescribing improperly or diverting, and we did some analysis on that, and I remember giving an

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opinion about that.
BY MS. SINGER:
Q. And was that the Top 200 program?
A. I don't remember that name.
Q. Okay. And do you recall what opinion you gave?
A. Yeah.
Q. And what was it?
A. That there were markers that would identify a clinic where the detail person should be concerned.
Q. And what were those markers?
A. I can't remember all of them now. But they were relatively straightforward; does it look like a medical office, is there a receptionist and files, do the patients in the waiting area look like a representative group of medical patients, was there anything unusual about the prescriber, were they interested in products other than strictly opioids. The other characteristics were things that you could look up online.
Q. And do you recall roughly when you offered those suggestions or indicators?
A. I can't remember.

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Q. Remembering your facility for dates.
Do you remember to whom you offered those views?
A. It might have been Sally Riddle.
Q. And do you remember what, if anything, happened as a result of your views?
A. I don't know.
Q. Okay. All right. And we were talking a minute ago about your voice with respect to marketing. Do you recall any opinions you offered on Purdue's marketing?
MR. SNAPP: Object to the form.
A. I don't recall.
BY MS. SINGER:
Q. All right. So let's go back to your CV, if we may, and you were reading a sentence regarding your role, your direction and support in the development of non-branded education. So what was that work in particular?
A. At one -- I remember that project because it was, I thought, a good one. At one point, as part of Purdue's remediation program, they developed, I think with an external party, a program for adolescents, children, schools and young adults, to deter experimentation with

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opioids, and it was probably the best program I'd ever seen.
Q. And you described it as part of Purdue's remediation efforts.
A. Well, that's what I would call it.
Q. Okay. And explain what you mean by that.
A. When something happens you do what you can to try to remediate it, to correct it, to minimize the damage, to make it better. I mean, after a hurricane you come in and try to both repair the damage and to remediate it to prevent future damage.
Q. And what was the -- what was the underlying problem that you were trying to remediate?
MR. SNAPP: Object to the form.
A. The rising abuse and diversion and addiction to all opioids.
BY MS. SINGER:
Q. And do you remember what the time frame was for this work?
A. It was when I was in my second -- well, I can't be sure, ma'am.
Q. And then the second part of that

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sentence in addition to the non-branded education was "focus group topics and concepts regarding reduced abuse liability opioids." Correct?

A. Yes, ma'am.

Q. And what did that work involve?

A. That was the Opioid X program. There were -- and I didn't run any focus groups, I had input to the people who did. There were problems perceived as possible with tamper-resistant and combination opioid products. The most -- the one I remember is why should I prescribe a drug that's got something in it that's not going to benefit my patient to benefit a drug addict, and one of the questions was, how did you talk about that? How do you convey to a physician that abuse and diversion are inherent in these drugs, all of them, and that that must be managed. That's part of their job.

Q. So, and when you talk about the question that was raised about prescribing a product that has something designed for drug addicts, I think you said, who was that question or concern coming from?

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MR. SNAPP: Object to the form.

A. That question came up from multiple parties. I mean, within my own team, the formulators, there were a number of people of multiple disciplines who said why should a patient take something that's not going to benefit them directly?

BY MS. SINGER:

Q. And what was the reason for including the naltrexone?

MR. SNAPP: Object to the form.

A. I think -- naltrexone, help me out, I don't understand your question.

BY MS. SINGER:

Q. Sure.

So you've been talking about this agent that was being added to opioids. Is that agent naltrexone?

A. Naltrexone was one of the agents that we considered for adding to opioids. The Opioid X program was very broad and had multiple intellectual properties and ideas associated with it, and one of them was adding naloxone and one of them was adding naltrexone. And there were multiple ways to do that, and there were

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multiple technologies that were under consideration.

Q. And what was the purpose of these various technologies?

A. The primary mode of abuse of controlled-release opioids is to crush the tablet and destroy its controlled-release properties, then to either snort it or put it in a teaspoon and inject it. And those are very high risk activities, and we wondered and tried to see if we could make it impossible to do that.

Q. And is it true, actually, that the primary mode of abuse of controlled-release opioids is taking them orally?

MR. SNAPP: Object to the form.

A. I actually can't answer that question accurately. Our concern with crushing, dissolving, injecting was that those were high lethality events, they could kill people.

BY MS. SINGER:

Q. Okay. I'm sorry, so there are -- is it fair to say there are multiple ways to abuse opioids?

A. There are multiple ways to abuse

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opioid drugs.

Q. And that includes taking more pills than you're prescribed, or taking the pills more frequently, is that correct?

MR. SNAPP: Object to the form.

A. You can take too much.

BY MS. SINGER:

Q. And then -- sorry, go ahead.

A. No, you could take too much.

Q. Okay. And then you're talking about another way of abusing them, which is snorting or injecting them, correct?

A. Yes.

Q. Okay. And so link this back, please, to the conversation about the other technologies. You were, I think, starting to get there.

MR. SNAPP: Object to the form.

MR. PETRILLO: Same. If you need clarification, you can ask.

A. What about the other technologies?

BY MS. SINGER:

Q. So when I asked you the purpose of the technologies, you started to explain that opioids can be abused by crushing or snorting.

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So what was the role of these technologies with respect to crushing and snorting and injecting opioids?
A. There were multiple goals, because some of the technologies could accomplish some things, some could accomplish other things. One branch of the technologies was intended to essentially render the opioid inert if you tampered with the pill. Another branch of the technologies was to make it physically very difficult to tamper with the pill. There was another group of technologies that would make tampering with the pill less lethal. And everything in-between. We quickly discovered when we were wrestling with this that tamper-resistance or abuse of -- tamper-resistance is the best word, was not an absolute, it was not a yes, no, could, or couldn't. There were grades. Some technologies were likely and very likely to prevent snorting. Some technologies prevented injecting. Some technologies prevented injecting and rendered the narcotic inert so that you couldn't get high from it or get a narcotic effect. There was even one technology that was essentially

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uncrushable. And all of these technologies were potential ways to make abuse and diversion more difficult.
Q. And you started by saying that there was resistance even among your own team to the use of some of those technologies, is that correct?
A. Yes, ma'am.
Q. And can you explain that again?
A. Yes. One objection that some of my peers felt might come up is why should a patient who is not abusing the drug be exposed to a second drug that they don't need and don't want to prevent abuse or diversion.
Q. And what was your own view of that?
A. Abuse and diversion are inevitable with any class -- any strong opioid, any Schedule II opioid.
Q. Is OxyContin a Schedule II opioid, a strong opioid?
MR. PETRILLO: I don't think the witness was finished.
BY MS. SINGER:
Q. Finish and we'll come back to it.
A. Limiting abuse and diversion, limiting

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a product's attractiveness for abuse and diversion protects the patient, it protects the doctor, it protects the product, it protects society.
So from my perspective when asked why should I -- you know, why is this essential for a product, I would say abuse and diversion is bad, it hurts people, and you need to address it.
Q. And I interrupted you inappropriately to ask if OxyContin was a strong opioid.
MR. SNAPP: Object to the form.
A. OxyContin is a Schedule II opioid.
BY MS. SINGER:
Q. And is that a strong opioid? I think you used that term, too.
A. Pure mu agonist opioid is more technically correct.
Q. So when you said strong opioid before, what do you mean?
A. Pure mu agonist.
Q. Okay. Which is -- OxyContin is a pure mu agonist?
A. Practically speaking. I don't know if it activates any of the other receptors, but it

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is predominantly a mu agonist opioid.
Q. You mentioned that there was an outside group involved in the non-branded education that you did. Do you remember what group that was?
A. No, ma'am, I don't.
Q. Who else worked with you on the non-branded education, if you recall?
A. I'm not even sure who worked with me. I remember being asked to review it, and I reviewed it.
Q. Do you remember who asked you to review it?
A. No, ma'am.
Q. And the focus group topics and concepts regarding reduced abuse liability opioids, who worked with you on the focus group piece of that?
A. I'm not certain there were focus groups on that. But that would have been Brianne.
Q. Brianne Weingarten?
A. (Nodding in the affirmative).
Q. And was there something else you could have been referring to with the use of focus

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groups in your CV?
A. I don't remember now.
Q. All right. So we're going to move forward to your role as executive director of risk assessment and health policy at the top of your CV.
One of the responsibilities you list for that position is potential product acquisitions. Was that part of your responsibility?
A. Yes, ma'am.
Q. And did that include any role in a project to inquire -- excuse me, a project to acquire technology from Grunenthal?
A. I remember Grunenthal. I'm not certain what -- I don't remember now what their product was.
Q. Okay. Do you remember anybody from Grunenthal with whom you worked or interacted?
A. I met them. I think we even presented Opioid X to them. But I don't remember anybody from Grunenthal.
Q. Okay. And do you remember what happened with that presentation, or after that presentation?

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MR. SNAPP: Object to the form.
A. I do not remember, ma'am.
BY MS. SINGER:
Q. And then in the same section of your resume you talk about "systems to assess and manage opioid drug abuse and diversion," which I think is the second bullet point under the third paragraph.
A. Yes, ma'am.
Q. Okay. Does that accurately describe one of your responsibilities in the position?
(Witness reviewing document.)
A. Patient is a bit much. We didn't actually do that much patient level work.
Q. And by "we," do you mean your division?
A. Yes, ma'am.
Q. Okay. And then the third bullet there, "Overall program." Do you see what I'm referring to?
A. Mm-hmm.
Q. And do you know what that work entailed?
A. That was our involvement with the whole RADARS program. And one of the early

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disadvantages in trying to grapple with abuse and diversion was the information systems that initially existed measured things like DAWN mentions or drug abuse warning system mentions or emergency room visits by pharmaceutical compound, hydrocodone, oxycodone, morphine, all generic terms. So there was no information on dosage form specific events, and there was no information on geographical distribution, or very limited.
The RADARS program was the first attempt to try to find out which pharmaceutical products were being abused and diverted, and where that was located, and when it was.
Q. So it is the RADARS program that you're talking about within this bullet item here?
A. Yes, ma'am.
Q. And what was your involvement with RADARS?
A. We, along with Sid Schnoll and David Haddox, we provided technical ideas about how you might do it.
Q. And apart from RADARS, you did have other sources of information about abuse and

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adverse effects, is that correct?
MR. SNAPP: Object to the form.
A. There were other sources of information.
BY MS. SINGER:
Q. And those included what?
A. Adverse event reports, direct contacts to the company, safety reporting, published literature. I'm not sure I got them all, but there were a variety of ways.
Q. Okay. All right. Let's turn to Exhibit 3.
Dr. Wright, if you need a break at any point, please just --
MR. PETRILLO: Is now a good time for a break?
MS. SINGER: Now is a fine time.
THE VIDEOGRAPHER: We are now going off the record, and the time is 10:08 a.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 10:16 a.m.
BY MS. SINGER:
Q. All right. Dr. Wright, we're going to show you Exhibit 3.

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(Whereupon, Purdue-Wright-3 was marked for identification.)
BY MS. SINGER:
Q. So Exhibit 3 is ENDO-OPIOID_MDL-3004266, and it's title Confidential Executive Profile, Curtis Wright, MD.
Dr. Wright, do you recognize this document?
A. I do not recognize this document.
Q. Were you aware of the firm of Heidrick & Struggles?
A. I am not aware of the firm of Heidrick & Struggles.
Q. Do you remember being considered or approached for a position at Endo Pharmaceuticals? I saw a bell visibly go off.
A. Yes, I remember.
Q. When -- I'm not going to ask you when. What did that involve?
A. To the best of my recollection, Robert Reder, after he left Purdue, went to Endo. When I was looking for a job I believe I interviewed with Robert.
Q. Understood.

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And you see a date here of April, 2005. Does that seem to be about the right timing?
A. Well, I hadn't actually left Purdue yet, I think. As I remember it, the news of the layoffs came during CPDD, sorry, a scientific meeting, and that's generally held in June.
Q. Okay. So that would have been June of 2005?
A. I think so.
Q. And which layoffs are you referring to?
A. The layoffs that resulted in my leaving Purdue.
Q. And what was the extent of that layoff?
A. I don't know how big it was across the whole company, but it was a -- it wiped out my department.
Q. The entire department?
A. No, my half of it.
Q. Your half was which half?
A. The scientific -- essentially the scientific research group, Dr. Kramer, Nab Dasgupta, my secretary. I think there was

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someone else in there, but I'm blanking on it at the moment. But I would be left as a department -- a party of one.
Q. Administer without a portfolio.
And the people who were let go, did they have a common function within the department, or what were their collective roles?
MR. SNAPP: Object to the form.
A. Doug Kramer was a medical officer. Nab Dasgupta was a bachelor who was working on his Ph.D who was a researcher in drug abuse. My secretary, who was our group's secretary. I don't know if the epidemiologist went then or not, I think so.
BY MS. SINGER:
Q. And who was the epidemiologist?
A. I've forgotten her name.
Q. Okay. And so was that the part of your department that worked on new drugs, or the part that worked on drug abuse?
A. Those were all people that worked on drug abuse.
Q. And were you given a reason for the layoffs at the time?
A. My understanding, which is just what I

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remember, was that there were financial reversals within the company.
Q. All right. So looking at this Exhibit 3, I want to direct you to Bates number 4268, which I think is Page 3, with 1998 to 2002 at the top.
Do you see where that is?
A. Mm-hmm.
Q. All right. And if you can look at the first bullet point, the very last sentence starting "Transfer to Medical Affairs." Let me know when you've found that.
A. Yes, ma'am.
Q. Can you read that sentence out loud, please?
A. "Transfer to Medical Affairs to work on Risk Management, a function that had not existed in the firm before that time and for which an urgent business need had arisen."
Q. And is that an accurate statement of your function and the circumstances?
A. At this point in time I'm not certain that it had not existed before.
Q. Okay.
A. And I've since learned that risk

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management has a specific meaning in both business and in pharmaceuticals, and I'm not certain that that is precisely correct either.

Q. And what do you mean by that?

A. From my perspective now, what I did mostly was try to develop within medical alternative products that would manage the risk of abuse and diversion, and to provide scientific and statistical methods that could do the same. But there was a whole other part of risk management that I wasn't doing.

Q. And was there someone else who was doing that?

A. Oh, yes, ma'am.

Q. And who was that?

A. Within medical, within the medical group it would have been Dr. Haddox, Dr. Schnoll, and all of the consultants that they had external to the company that were working on the product-specific reporting systems. There would have been -- I don't even know all the other people that were involved, but there were.

Q. And do you remember who the external consultants were?

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A. No.

Q. Okay. And was there a person who held your position before you?

A. No, ma'am.

Q. Okay. And do you know what the instigator or trigger was for creating your position?

A. I don't know for sure at the level of senior management.

Q. So you don't know who the person was?

A. I have a strong suspicion.

Q. And what is your suspicion?

A. That Dr. David Haddox was instrumental in setting up that group.

Q. And on what do you base that?

A. Well, he suddenly became my boss. But when I had started at Purdue there was nobody with the epidemiological research/scientific analysis functionality working in the medical department, and suddenly that group appeared, and it appeared as a result of Dr. Haddox and he became my boss. So that's what I base it on. I think he did it.

Q. And was there a triggering event or circumstance inside or outside the company that you think prompted it?

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MR. SNAPP: Object to the form.

A. I may have had something to do with it.

BY MS. SINGER:

Q. In what way?

A. Well, Dr. Haddox believed, as I did, that all opioid drugs are vulnerable for the development of an abuse and diversion problem, all of them, and that when they happen they happen fast, and you had to respond fast and you had to do something about them.

And one of the things I do remember early on was that Dr. Haddox said, Curt, how can we convince them, how can we explain that when this happens it will happen fast, and we need to do something? And so I provided him with coaching on what might happen.

Q. And when you talk about "them" in that sentence who needed to be convinced, who are you referring to?

A. The company as a whole.

Q. And when you say you gave him coaching, what did that involve?

A. I remember him asking me what could

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happen, and I told him what could happen, because I'd seen it happen.

Q. And what could happen?

MR. SNAPP: Object to the form.

A. The short -- there's a long answer, and the short answer that's probably better is a triggering event occurs that the company has to analyze, interpret, and respond to in a corrective way right away.

BY MS. SINGER:

Q. And when you say you had seen it before --

A. I was -- yes.

Q. -- what had you seen before?

A. What was the question?

Q. What had you seen before?

A. When I was at the Food and Drug Administration I was head of the drug abuse group, so all of the various abuse, diversion, crises that occurred during eight or nine years came through my desk.

Q. And when you say you had to -- there would be a triggering event, you'd have to act fast, is that because the speed, the scale of what was going to happen, the lethality? I

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mean, what are you talking about with that?
MR. SNAPP: Object to the form.
A. When an event occurs, early on you have the potential to stop it. When it's become widespread it's too late, you then have to try to do what you can.
BY MS. SINGER:
Q. And did the event of the abuse and diversion of opioids become widespread?
MR. PETRILLO: Object to form.
A. I think it is evident that there is a widespread problem with abuse, diversion and addiction to all opioid drugs that we're in the middle of right now.
BY MS. SINGER:
Q. And when you talk in this Exhibit 3 about an urgent business need, what was that urgent business need?
A. A responsible company has to do something.
Q. To prevent that kind of harm?
A. Prevent it --
MR. SNAPP: Object to the form.
A. A company, from my perspective, that's behaving properly anticipates what might happen,

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is ready to identify what does happen, is able to analyze when that does -- what the event is to find what's truly happening, and then has thought about what they might do to correct it.
BY MS. SINGER:
Q. And those are all hallmarks of a responsible company, correct?
MR. SNAPP: Object to the form.
A. I believe they're part of business responsibility.
BY MS. SINGER:
Q. And when you talk about what you had seen in your years at FDA with other incidents or epidemics of drug abuse, what were those?
A. They were so mixed and varied, I can't -- it's difficult to do on the spot.
Q. So you've --
MR. PETRILLO: I'm sorry, were you finished?
A. Can you rephrase the question? Maybe I can answer it.
BY MS. SINGER:
Q. So turning to your point about the incidence or abuse epidemics you had seen at FDA, did any of them relate to opioids?

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A. Yes.
Q. Which opioids?
A. Do you wish me to include those that occurred at FDA that were historical that I had to learn about as the part of my job, or those that actually occurred when I was -- on my watch?
Q. Let's do both. So let's start with the ones you learned about that preceded you.
A. Okay. During the -- I'm not sure of the time frame. There has always been an effort to try to develop less abusable opioids. Some of the less abusable opioids were the partial agonist or mixed agonist/antagonist opioids, these are things like Talwin. I'm blanking, it's been too long. I used to know them by heart.
Those were developed and were put in lower schedules of the drug abuse scheduling categories because it was believed and sometimes hoped that they would have less abuse potential. Some of them developed widespread abuse problems and had to be rescheduled. Some of them developed local outbreaks of abuse that had to be controlled. Some of them developed sentinel

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cases that were so horrific that the company had to respond because the case was so tragic.
And so there was always pressure to schedule, up-schedule drugs, there were always pressures to do something to try to intervene in abuse and diversion outbreaks.
Q. And that pressure came, in your opinion and experience, from a desire to protect patients and public health, is that right?
A. Yes, ma'am.
Q. Okay. So that's the historical piece that you were talking about, is that right?
A. I blurred because --
Q. Okay.
A. That is also the things that happened on my watch, some of the things that happened on my watch.
Q. And those things would be known to a responsible company that was making and marketing opioids, correct?
MR. SNAPP: Object to the form.
A. That's tricky, because during that time, not now, it's been too long, but during that time I was an expert on pharmaceutical problems associated with abuse of opioids. I'm

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not sure that most pharmaceutical physicians would have the breadth of knowledge that I had at that time.
BY MS. SINGER:
Q. That's all knowledge you brought with you to Purdue when you joined in 1998, correct?
MR. SNAPP: Object to the form.
A. I brought what I could with me to Purdue in 1998. I was still subject to the Ethics in Government Act and the confidentiality requirements of the FDA, so there were things that I knew about that were not in the public domain that I could not talk to people at Purdue about.
BY MS. SINGER:
Q. But could you talk to people at Purdue about the history and experience of drug abuse and drug diversion with opioids?
MR. SNAPP: Object to the form.
A. I was perfectly free to do that.
BY MS. SINGER:
Q. All right. And did you do that?
A. I did do that.
Q. So let's go back to Exhibit 3. At Bates number 73, so turn forward if you would,

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it's the page that has "Spyker" at the top of it. And do you see about halfway down an item -- a publication that starts "Reder R"?
A. Mm-hmm.
Q. What is that publication?
A. It looks like an abstract presented at CPDD.
Q. And that's an abstract that you wrote in 1993, correct, or co-wrote?
A. I believe I was cited as one of the authors.
Q. Okay. Do you see yourself listed as one of the authors?
A. Yes, I do, ma'am.
Q. Okay. And who were the other two authors?
A. Robert Reder and Bob Kaiko.
Q. And were they both at Purdue Pharma?
A. At that time I believe they were.
Q. And is that typical to co-author publications from regulated entities? You were at FDA at the time, they were at Purdue Pharma, yes?
MR. SNAPP: Object to the form.
BY MS. SINGER:

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Q. Was that typical for an FDA official to co-author an abstract with pharmaceutical executives?
MR. SNAPP: Object to the form.
A. It depends on the division. In some divisions it was not quite typical, in other divisions it would not happen.
BY MS. SINGER:
Q. Okay. And do you remember how this abstract in particular arose?
A. I don't remember the abstract at all.
Q. Okay. And moving down your list of publications under the "Presentations At Symposia and Scientific Meetings," do you see the publication "Abuse Liability and Drug Scheduling"?
A. Yes, ma'am.
Q. And is that a publication you still have? Would you have retained a copy of that?
A. I don't think so.
Q. Okay. What about moving down that page, "Beyond Compliance with FDA Regulations"?
A. That looks like it occurred at Purdue.
Q. Okay.
A. Everything that I did at Purdue I left

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at Purdue.
Q. Okay. Now, once you left Purdue, you did not go to Endo, is that correct?
A. I did not go to Endo.
Q. Where did you go?
A. After I left Purdue, I attempted to support myself as an independent consultant, pharmaceutical consultant. I was unsuccessful in this. I eventually was contacted by Dan Carr who asked me to come work on one of his projects that later became Javelin Pharmaceuticals.
Q. Is Dan Carr a professor in Boston?
A. Dan Carr is a professor in Boston, and a well-recognized analgesic expert.
Q. Were you still at Purdue when Purdue pled guilty to a series of misdemeanors relating to its misbranding?
MR. SNAPP: Object to the form.
A. When did that occur, do you know?
BY MS. SINGER:
Q. 2007.
A. No, ma'am.
Q. And when you were at Purdue, did you interact directly with any member of the Sackler family?

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A. Very rarely. I interacted with them socially on two or three occasions. I had a couple of conversations with Dr. Richard or Dr. Kathy because they were wanting to ask me questions about some new thing they were interested in, and that's about it.
Q. And do you remember the specifics of any of those conversations?
A. I can't be certain. I think one of them involved someone who was presenting a novel inhaled analgesic. The other one I don't remember.
Q. Okay. And did you ever interact with them in particular on Opioid X?
A. Well, it depends on what you mean by "interact with them." We gave multiple presentations on Opioid X, and I'm sure that some of them the Sacklers were at because it was the annual scientific meeting or they came, but I was just giving my presentation.
Q. And the annual scientific meeting was what?
A. At one point during the year, and I don't remember when it was, we would present to the Sacklers what had happened to the -- what

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was -- what had happened, what was under development, future directions that we might go. We just got an assignment, and we did our assignment and presented it.
Q. Okay. And that's what you refer to being the annual scientific meeting, it was a meeting between officials in the company and the Sackler family?
MR. SNAPP: Object to the form.
A. It was a pretty big show, because I think it was also to some of the other employees who weren't directly involved in the research, so it was usually held in a large venue. I don't know how frequently for sure, but I know about it because I inadvertently sat in the Sackler family section and quickly got shooed out.
BY MS. SINGER:
Q. Were you aware -- or was Purdue, to your knowledge, involved in the development of any addiction treatment drugs during your tenure?
MR. SNAPP: Object to the form.
A. I truly don't know, because we had for a period a drug development -- a drug discovery

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unit, and I don't know all of the things that they worked on down there.
BY MS. SINGER:
Q. Was the drug discovery group Purdue Research Center, or did it have a different name?
A. I was only there twice, and I'm not sure I know what the proper title of that place was.
Q. Okay. Did you receive any deferred compensation when you left Purdue, any kind of severance or...
A. To my recollection, I received a severance package when I left Purdue.
Q. And are you being compensated for preparing or testifying today?
A. Not to my knowledge.
Q. You should probably know.
And do you know if Purdue is paying for your counsel?
A. I hope Purdue is paying for my counsel.
Q. Fair enough.
All right. Let's turn back to your time at the FDA. So I think you've already

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testified, if not I'll ask you again, you worked on the new drug application for OxyContin, correct?
A. That is correct.
Q. And had you been involved with oxycodone related products before, oxycodone products before?
A. I don't remember.
Q. And had you been involved in any controlled-release product approval?
A. Yes.
Q. And had you ever been involved in assessing or approving the controlled-release version of an existing drug?
A. Could you repeat the question?
Q. Yes.
Had you ever been involved in assessing or approving the controlled-release version of an existing drug?
A. Yes.
Q. Do you remember which one that was?
A. There were -- no. There were a bundle of opioid controlled-release forms that came piling in, and I was involved -- would have been involved with them, but I don't remember them

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one by one.
Q. Do you recall what you were looking for in deciding whether to approve OxyContin?
MR. SNAPP: Object to the form.
MR. PETRILLO: Objection.
Let me just direct you, Dr. Wright, not to reveal any communications within FDA, which I don't think you're permitted to do.
A. I can speak of my own, for myself personally. I cannot speak for the FDA. The FDA speaks for the FDA. When a -- there was a -- I won't say fad. But there was a period in which controlled-release technology made advances, and people brought in a variety of drugs wishing to have controlled-release dosing, and those were referred to as immediate-release to controlled-release switches.
The important features that were always looked at by me were what's the peak concentration at the proposed dosing interval, what's the trough concentration, are there any safety hazards associated with the product that are associated with its controlled-release features, and where it needed to be, where appropriate, what was the clinical efficacy

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outcomes and what were -- were there any unanticipated safety outcomes. That's what I would look for.
BY MS. SINGER:
Q. And can you just explain briefly the difference between an immediate-release and a controlled-release drug?
A. Yes, I can.
Q. Could you?
A. An immediate-release drug, the absorption is determined by the drug theoretically dissolves immediately upon entry into the stomach, and then is absorbed at a rate that's determined by the transmission across the stomach into the bloodstream and passage through the liver and lungs.
For a controlled-release, the tablet has some intrinsic property, tablet, patch, lozenge, something you put in your mouth, there's all kinds of different ways, has some intrinsic property that slows the release and delivers the drug over time.
Q. Okay. And you talked a minute ago about looking at the peak concentration. Can you explain what that is?

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A. When you -- yes, I can.
Q. Please go ahead.
A. When you take a drug you have -- we'll assume you haven't taken it before, there's a lag because you have to get into your stomach, and then the blood level in your blood will start to rise, it will reach a peak, and then it will start to fall, and then it will fall to subtherapeutic levels.
Q. And why does the peak matter?
A. Generally the speak is associated with the peak effect and the peak toxicity.
Q. Okay. Meaning that's when you get the benefit of the drug?
MR. SNAPP: Object to the form.
A. And the bad things.
BY MS. SINGER:
Q. And then you talked about looking at the trough, correct? And why does the trough matter to you?
A. The trough is when the effect can wear off, and the drug is no longer providing the benefits to the patient.
Q. Okay. All right. So you mentioned before you're looking at the peak, you're

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looking at the trough, I think you also said, correct me if I'm wrong, that you're looking at efficacy. When you were looking at the efficacy, did you want to see that the controlled-release had the same efficacy as the immediate-release?
MR. SNAPP: Object to the form.
A. Desirable, but not necessary.
BY MS. SINGER:
Q. Okay. And did it matter from -- well, at the time OxyContin was assessed and approved, was there any discussion of what it would be scheduled as?
MR. SNAPP: Object to the form.
A. You're asking about discussions that took place within the Food and Drug Administration, and that is privileged, I believe.
However, oxycodone is a Schedule II opioid, and I cannot imagine it ever being anything but a Schedule II opioid.
BY MS. SINGER:
Q. Okay. Now, you were the medical officer who also reviewed the studies Purdue submitted with its application, correct?

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A. No.
Q. Did you review any of the studies?
A. Yes, I reviewed all of them, but I was not the primary reviewer on some of the studies.
Q. And FDA doesn't conduct any of its own studies in approving a drug, does it?
MR. SNAPP: Object to the form.
A. You're asking a question that extends beyond my knowledge, because FDA does conduct studies and it -- but it is not routine for pharmaceutical company applications for -- well, FDA does conduct studies. The extent and magnitude of studies that they conduct and when they conduct them is beyond my knowledge because it is so broad.
BY MS. SINGER:
Q. Did FDA conduct any of its own studies related to OxyContin?
A. Prior to approval?
Q. Yes.
A. Not to my knowledge.
Q. Did it conduct any studies after its approval?
A. If they occurred after '97, I wouldn't know.

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Q. Okay. And in assessing and approving OxyContin, the new drug application for OxyContin, you relied on the studies that Purdue submitted and the general literature, correct?
MR. SNAPP: Object to the form.
A. As a matter of policy we would have relied upon the studies that were conducted by the company, the reports of the division of scientific investigations on the conduct of those studies after they investigated them, our general knowledge, the results of other -- other science that the agency held that would tell them about the safety or efficacy of a potential product, general knowledge of the reviewers, and I think that's about it.
Q. Okay. And as part of the approval process you developed a package insert, correct?
A. No.
Q. Okay. Correct --
A. The company developed a package insert.
Q. Okay. And you worked with Purdue on various drafts of that package insert, is that correct?
A. Everyone involved would work with

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Purdue on various drafts.
Q. And the original draft of the package insert you said came from Purdue?
A. Yes, although at that time it was fairly common for us to provide companies with an outline of what we were trying to move the controlled substances package inserts towards. They were very heterogenous because they covered a 30, 40 year span, and some of them were very good and some of them were very bad, and I was directed by my division director.
MR. PETRILLO: Objection.
If you can testify without talking about conversations or directions from within the FDA, that would be preferable.
THE WITNESS: Yes, I'm sorry.
MR. PETRILLO: If you want to testify to what you actually did, that's fine.
A. Okay. I had for some reasons a goal of trying to get a good package insert for all the narcotics that were coming in for re-review or new review.
BY MS. SINGER:
Q. And what's a good package insert?
A. One that has a reasonably -- has

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reasonably uniform language, is comprehensible, is clear, and has easy to find sections in which you can find specific information that you need to know as a doctor.
Q. Now, there is a separate division at FDA that oversees some of the promotional activities related to prescription drugs, correct, that didn't fall in your division?
A. No, there's the division of drug advertising.
Q. Okay. Also known as DDMAC, correct?
A. DDMAC.
Q. And you weren't directly involved in overseeing the promotion of OxyContin?
MR. SNAPP: Object to the form.
A. I was not directly involved in overseeing the promotion of OxyContin.
BY MS. SINGER:
Q. Okay. And you seemed to hesitate. Was there a reason for that?
A. Yes. DDMAC often used us as a technical reference.
Q. And were you a technical reference in any of the promotion relating to OxyContin?
MR. SNAPP: Object to the form.

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A. I think you're asking about -- I think I can't answer that properly.
BY MS. SINGER:
Q. Okay. So as a matter of policy and practice, the FDA's marketing oversight is related to marketing or promotional pieces that are distributed by a pharmaceutical company, is that correct?
MR. SNAPP: Object to the form.
A. To my understanding, yes.
BY MS. SINGER:
Q. Okay. And the FDA does not have a role in all of the different ways that a prescription drug is promoted, correct?
MR. SNAPP: Object to the form.
A. I truly don't know. I know that we have -- that the FDA had a division of drug advertising. I do not know the breadth or extent of their responsibilities or powers.
BY MS. SINGER:
Q. Okay. And do you have a view as to who is responsible -- a view as to whether it's a drug company's responsibility to ensure that its marketing is accurate and fair and balanced?
A. My understanding of the regulations

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are that a drug company has a responsibility to meet the DDMAC guidelines in marketing their product.
Q. And that includes making sure that their advertising is fair and balanced and accurately conveys the risks and benefits of a product?
MR. SNAPP: Object to the form.
A. It's hard to be accurate in answering you because I didn't work in DDMAC, and I don't know the extent to which their -- I don't know their standards.
BY MS. SINGER:
Q. Fair enough.
Looking at it from the perspective of the label, then, which is really where you were working, is that correct?
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. The FDA -- the fact that there is an FDA-approved label and package insert -- I'm sorry, let's step back.
What is a package insert?
A. A package insert is the full labeling information -- full prescribing information for

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a drug which should be reviewed by anybody who prescribes it, and is a source document that is used to assess the use, dosage, safety, and special precautions involved in prescribing a drug.
Q. And do you remember roughly how long the package insert was for OxyContin, how many pages?
A. Many.
Q. Can you count them on your fingers again, or do we have to get extra hands?
A. It would depend on the typeface. But 20, 30.
Q. Pages?
A. (Nodding in the affirmative).
Q. Okay. And the fact that there is -- and the FDA approves the package insert, correct?
MR. SNAPP: Object to the form.
A. It's difficult because I don't know whether the FDA approves a package insert or does not object to a package insert, but the FDA certainly reviews a package insert.
BY MS. SINGER:
Q. Okay. And the fact that the FDA has

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reviewed or approved a package insert, whatever the right term is, the right verb, that doesn't prevent a company like Purdue from warning of additional risks that become known to it, is that correct?
MR. SNAPP: Object to the form.
A. That's a tough problem, because I don't know if a company -- and it's come up. I don't know if a company can provide additional -- can change its package insert to provide additional warnings without notifying the agency and getting their lack of disapproval or approval, whatever it is. I don't know for sure.
BY MS. SINGER:
Q. You don't know. Okay. We'll leave it there then.
There are other ways that a drug company discloses risks to prescribers and patients, correct, outside of the package insert?
MR. SNAPP: Object to the form.
A. You're asking questions about DDMAC practice that I -- that are beyond my expertise.
BY MS. SINGER:

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Q. Okay. So turning away from DDMAC, is it fair to say that a pharmaceutical company is responsible for ensuring that the drugs they sell are safe and effective?
MR. SNAPP: Object to the form.
A. Again, that's tricky, because it's safe and effective used as directed. And the goal of the whole FDA approval process is that the product reaches the market safe and effective used as directed.
BY MS. SINGER:
Q. And that -- and is it fair to say that there's an expectation that there's an alignment between the indication and the use?
MR. SNAPP: Object to the form.
A. That is a -- no. That is a painful and sore point. The FDA is federal, and it regulates the pharmaceutical industry. The regulation of the practice of medicine devolves to the individual states. So it would not be unusual for a medication to have off-label use and off-label indications that are not referenced in the package insert, but which are used by physicians.
BY MS. SINGER:

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Q. Off-label indicate -- actually we don't need to go down that rabbit hole.
And a drug company in its outreach in marketing a product interacts with healthcare prescribers, healthcare providers about the use of its drug, correct?
MR. SNAPP: Object to the form.
A. Yes, ma'am.
BY MS. SINGER:
Q. And when we get into the regulation of that we leave your area of expertise, correct?
A. (Nodding in the affirmative).
Q. Okay. Let's turn to the next exhibit, which is 1484.
(Whereupon, Purdue-Wright-4 was marked for identification.)
MS. SINGER: I think we're back down to two of these. Exhibit 4 is PKY180764184. And it's titled Project Team Contact Report.
BY MS. SINGER:
Q. And, Dr. Wright, I see you're looking at it. Is it familiar to you, this form of document?
(Witness reviewing document.)
A. No. This is a company document.

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Q. Okay. "A company" meaning a Purdue document?
A. (Nodding in the affirmative).
Q. Okay. And if you can take a look at the content of the discussion, and just read it to yourself for a moment.
(Witness reviewing document.)
Q. Do you recall the discussion that's described in this project team contact report?
A. No, I don't, ma'am.
Q. Okay. Do you recall talking to Dr. Reder about osteoarthritis studies related to OxyContin?
A. This document says that I did. I don't remember.
Q. Okay. All right. Let's turn to --
(Whereupon, Purdue-Wright-5 was marked for identification.)
BY MS. SINGER:
Q. Exhibit 5 is PDD 9520512001. And it's titled -- it is the second exhibit from the deposition of you, Dr. Wright, July 25th of 2003, the font is really difficult, but I'd like to direct you to Bates number 263.
All right. Do you see your name as an

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FDA attendee in the middle of this page?
A. Yes.
MR. SNAPP: Do you think we could give the witness the time to just look through the document to make sure he knows what it is?
MS. SINGER: If he needs it, absolutely.
MR. SNAPP: Thank you very much.
(Witness reviewing document.)
BY MS. SINGER:
Q. All right. Do you recognize this document, Dr. Wright?
A. (Nodding in the negative).
Q. Okay. Do you see --
A. I'm sorry, I have to respond verbally. I don't remember it now.
Q. Okay. Thank you for policing yourself on that.
Do you see yourself in the middle of Bates number 263 as an FDA attendee at this meeting?
A. Yes, I do, ma'am.
Q. Okay. And do you know who Ms. Emmet is?
A. She would have been a consumer safety

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officer at the Food and Drug Administration.
Q. Okay. And do you see, if you look at the first line on the paragraph, the bottom paragraph that starts "Ms. Emmet began the meeting with a strong recommendation that Purdue Frederick participate in the Pilot Drug Division's pilot management system for reviewing drug development programs."
Do you see where I am?
A. Yes.
Q. What is the pilot drug division project management system?
A. It was how we handled new drug applications or drug development programs with companies when we could.
Q. Okay. And what was the pilot about it?
A. When I was hired into the FDA, I was initially to go to the neuropharm division, but between the time that I applied and I showed up the drug class that I was working with had been transferred to something called the pilot drug evaluation staff, and that was a division that reported directly to the center director and was led by Dr. John Harter that was specifically

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tasked with improving the agency's effect -- the Center for Drug's effectiveness in reviewing new drug applications.
Q. Okay. And when you talk about the center, just tell us which center it is.
A. Center for Drugs.
Q. Okay. Is that also known as CDER?
A. Yes, ma'am.
Q. And it says here -- so do you know if Purdue participated in the pilot drug division's project management system in its application for OxyContin?
A. I believe they did.
Q. Okay. And if you move down this paragraph, about four lines up it says "Each interaction between FDA and PF should be recorded and submitted to the IND (batching of records may be done on a regular basis). The timelines for each of FDA's projects is reviewed monthly at FDA, a meeting to which the PF project manager is also invited. PF is responsible for keeping minutes of all meetings. These will be official minutes unless FDA disagrees."
Have I read that correctly?

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A. You have read that correctly.
Q. Okay. And so PF is Purdue Frederick. And the IND is what you talked about earlier, the drug approval process?
A. No, the IND is investigational new drug application which is the document that permits new drug studies to be started and done.
Q. Okay. So do you recall Purdue submitting minutes of its meeting with FDA, and you in particular?
A. They would have gone to Ms. Emmet or to the other consumer safety officer, and I may or may not have seen them. I don't remember any of them.
Q. Okay. And do you know whether it was the practice of Ms. Emmet or FDA to review these minutes?
A. It was my belief that they did.
Q. And then while we're in this document, let's turn the page to 265. Right in the middle of the page it says "Dr. Wright will send his FDA's high dose opioid policy to facilitate our generation of labeling with respect to the warning section."
Do you see where I am?

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A. I see where you are.
Q. Okay. And what is the FDA high dose opioid policy?
A. I don't know it by that name. With, I think it was -- I cannot remember the product but I think it was Duragesic, it was the first time that a company submitted a request for a high dose opioid that would be too high to give to an opioid naive patient, someone who had not received opioids before, that if by accident it was prescribed or used for a patient that was not -- did not have opioid tolerance, that they could get sick or die. And I was, as a reviewer and as a doctor, very concerned about that. And I remember struggling with how to identify, flag, package, think about, label such products so that such accidents wouldn't happen.
Q. Okay. And so that's what you think is expressed by the high dose policy?
A. I think so.
Q. Okay. And do you know if there's an official document that reflects it?
A. I don't know.
Q. And then let's turn to Exhibit 5 -- 6.

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(Whereupon, Purdue-Wright-6 was marked for identification.)
BY MS. SINGER:
Q. And Exhibit 6 is PPLPC018000725809 titled "Criticisms and Allegations Potentially Requiring Response in Connection with the Senate Finance Committee Inquiry."
Are you familiar with this document?
A. No, I am not, ma'am.
Q. Okay. So I just want to turn to Bates number 809 -- that's wrong. 5857. And you see the section -- I'll let you get there. You have your own heading, "Purdue did not improperly influence Dr. Curtis Wright."
Do you see that?
A. Yes.
Q. And do you see halfway through the page in the paragraph beginning "Critics," three lines from the bottom of that paragraph, "Purdue recorded all communications with Dr. Wright, whether formal or informal, in internal contact reports, and submitted summaries of such reports to the FDA on a regular basis."
Do you see that?
A. Yes, I do.

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Q. Okay. And does that seem consistent with what we were just talking about with the regulatory contact reports?
MR. PETRILLO: Objection to form.
A. I only know my side of communications with Purdue and with other companies during that period of time, and we simply never met with the company alone and always had the consumer safety officer with us. So the consumer safety officer should have had personal access to either the communication as it was occurring and her notes, or whatever notes the company may have written.
BY MS. SINGER:
Q. Okay. And that would have been Ms. Emmet in this case?
MR. SNAPP: Object to the form.
A. Consumer safety officers sometimes covered for each other and changed in the course of a project, but it would have been whoever the duty consumer safety officer was.
BY MS. SINGER:
Q. Okay. All right. I want to turn back to what was Exhibit 4, which is the project team contact report, which is PKY180764184. It's the short one, Dr. Wright. I may have given the wrong number.
A. Okay.
Q. Okay. Is that Exhibit --
A. 4.
Q. -- 4? Okay.
All right. And I know you didn't recall this document, but I just want to see if any of the content here refreshes your recollection. It says three lines down, "Of greater importance is the fact Dr. Wright said that for certain individuals in the division and in the agency, the use (i.e., long-term) in osteoarthritis is unwarranted."
Do you recall saying that to Purdue Pharma?
A. I don't recall it, but it is very likely.
Q. And what do you base that on?
A. Our division -- as a matter of policy, our division was very sensitive to claims for therapeutic efficacy and osteoarthritis because we also handled the non-steroidal anti-inflammatory drugs, and that is a huge issue with that class of drugs, and I can readily believe that I made explicit statements

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to Purdue that this is not a drug for unselected OA.
Q. OA is?
A. Osteoarthritis.
Q. It goes on to say "The way the protocols are written, it looks as if Purdue Frederick is attempting to obtain labeling claims for pain from osteoarthritis. This will be strongly resisted."
That strikes you as true as well?
MR. PETRILLO: Objection.
A. It is very typical of what we would have said.
BY MS. SINGER:
Q. Now, osteoarthritis, if you know, is a fairly prevalent condition, is it not?
MR. SNAPP: Object to the form.
A. As with most medical conditions, it depends on what you mean. Osteoarthritis can be my fingers are a little sore in the morning, and osteoarthritis could be I can't walk, and I've been out of it too long to know what the current numbers are for severity by diagnosis.
Q. Or prevalence, just what percentage of the population has it?

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A. Osteoarthritis is common. Severe osteoarthritis is less common.
Q. And then if you keep going down this page, it says single -- "and that Purdue Frederick recognizes single-entity opioid use is not appropriate except in a highly selected subpopulation."
Do you see where that is?
A. Yes, I do.
Q. And does that seem accurate to you as well?
MR. PETRILLO: Objection.
MR. SNAPP: Object to the form.
A. I don't -- reading it now, I don't know what Purdue recognized or didn't recognize.
BY MS. SINGER:
Q. Okay.
A. The statement that opioids are not -- single entity opioids are not for general use in osteoarthritis is medically, to my opinion, true.
Q. Is what?
A. To my opinion is medically true.
Q. A single entity opioid is what?
A. One which does not contain another

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analgesic agent.
Q. Like acetaminophen, for instance?
A. Like Tylenol or NSAIDs or...
Q. And OxyContin is a single entity opioid, correct?
A. Yes, it is.
Q. Okay. So last line from this, if you can look at, "If we wish to perform a long-term study in osteoarthritis patients, we should study highly selected patients. Such a study should include questionnaires and data collection directed toward evaluation of abuse, evaluation of diversion, increased use with time (tolerance), efficacy and safety."
What do you understand this to mean?
MR. SNAPP: Object to the form.
A. If an indication, a label indication in osteoarthritis is sought, then it's a big job.
BY MS. SINGER:
Q. Then it's a big?
A. Job. It's a much -- it is a much bigger application.
Q. Meaning the sponsor, the applicant, has to submit --

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A. The applicant has a much higher burden of proof.
Q. Okay. And that would include a study, correct?
A. Well, that was our -- yes, that was our opinion. If this is an accurate document, I don't see a reason why it's not, we said that they needed to do a lot of safety work to -- and efficacy work to promote the drug for any, but highly selected cases of osteoarthritis.
Q. Okay.
MR. SNAPP: Is this a good time for a break?
MS. SINGER: Let me just finish this document.
MR. SNAPP: Absolutely.
BY MS. SINGER:
Q. And the study included outcome measures related to abuse, diversion, tolerance. Let's stop with those three. Do you know why those would have been elements or outcomes on which you were focused?
MR. SNAPP: Object to the form.
A. I know why now, if I can answer in the present.

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BY MS. SINGER:
Q. Sure.
A. Abuse, diversion, tolerance, and withdrawal are always issues with the chronic use of opioids.
Q. And you answered that now. What would your answer have been in 1993?
MR. SNAPP: Object to the form.
A. Okay. To the best of my recollection, abuse, diversion, tolerance, and withdrawal would have been important questions about the chronic use of any opioid.
BY MS. SINGER:
Q. Okay. Which seems confirmed by the elements of this study?
MR. SNAPP: Object to the form.
MS. SINGER: All right. I think now is a good time for a break.
THE VIDEOGRAPHER: We are now going off the record, and the time is 11:24 a.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 11:36 a.m.
BY MS. SINGER:
Q. All right. We're going to start with

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another exhibit, Dr. Wright. This way we go home with less paper. So this is Exhibit Number 7, it is PKY180761078. And please take a minute and see if you recognize this document.

(Whereupon, Purdue-Wright-7 was marked for identification.)

(Witness reviewing document.)

BY MS. SINGER:

Q. The longer we're here today the smaller the font gets. So I'm going to pose the question, whenever you're ready to answer, please do.

Do you recognize these to be minutes of a meeting between Purdue Pharma and the FDA. And if you don't recognize it, that's fine, too.

A. I don't recognize this document.

Q. Okay. I want you to turn to Bates number 1088 and see if you are familiar with the conversation described here.

So if you look at Paragraph 8 that starts Dr. Lacouture, I'm sure I didn't say that correctly, and it says -- it's talking about an OA extension study, correct?

A. What I read here is an extension study that is proposed.

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Q. Okay. And that's related to OxyContin, correct?

A. I believe so.

Q. Okay. And it says here that you said -- "Dr. Wright said that while these data are valuable, he would not allow advertising for the management of osteoarthritis. To promote in this area we would need several more controlled studies and then review of the data by at least two FDA advisory panels."

Do you recall having that conversation?

A. I do not recall having that conversation. It, however, sounds like me.

Q. Okay.

MR. PETRILLO: I think you may be blocking your mic.

BY MS. SINGER:

Q. All right. And this is consistent again with your prior remarks, that it would be a heavy lift or a big load, or whatever phrase you used previously?

MR. SNAPP: Object to the form.

A. Was that a question?

BY MS. SINGER:

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Q. Yes. Is that correct?

MR. SNAPP: Object to the form.

A. What is written here, which says that there would be a heavy data requirement, and that it would likely be reviewed not only by the drug abuse advisory committee but the arthritis advisory committee is correct.

BY MS. SINGER:

Q. Okay. All right. We're going to turn to Exhibit 8.

(Whereupon, Purdue-Wright-8 was marked for identification.)

BY MS. SINGER:

Q. And Exhibit 8 is PDD7024302094.

A. Is this the same? Does it come apart?

MR. PETRILLO: You keep that one.

BY MS. SINGER:

Q. And it's titled "Author: Dr. James Conover."

Do you recognize that name?

A. I've heard the name before. I'm not sure I know who James Conover is now.

Q. Okay. Was he at Purdue, or FDA, if you recall?

A. I think he was company. I'm not sure

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he was Purdue.

Q. Okay. All right. And the date of this document is 9/15/94, correct?

A. Mm-hmm.

Q. And its subject is "FDA Meeting Minutes," correct?

A. Yes.

Q. Okay. I want you to turn, if you will, to Bates number 2102, just towards the end of the document. If you look about halfway down, why don't you read this time, if you would, "Dr. Wright stated he had a little trouble." Do you see where I am?

A. Yes. "Dr. Wright stated he had a little trouble with the claim 'the drug to start with and stay with' because he was unsure of titration with OxyContin tablets. He offered the idea of marketing a 10-milligram IR oxycodone tablet to have patients titrated on first and then be switched to OxyContin."

Q. Okay. You can stop there.

So do you recall this conversation?

A. No, I do not.

Q. Okay. And do you understand what this language is referring to?

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A. Well, I can only -- I mean, I can only say what it says in this document, which is, I think, is likely to be correct-ish.
Q. Okay.
A. The drug to start with and stay with sounds like a marketing phrase, and it's not -- what it says here sounds like me, and most physicians would start with an IR drug --
Q. And IR is immediate-release?
A. Immediate-release drug.
-- and then switch to a controlled-release, unless the patient's condition warranted going directly to a controlled-release drug.
Q. Okay. And is it fair to say that before OxyContin was launched you were concerned about positioning OxyContin as the first opioid to try?
MR. SNAPP: Object to the form.
A. I truly can't remember if I was concerned with it at that time.
BY MS. SINGER:
Q. Okay. Let's move on to 185. Oh, we've done it before?
MS. FORSTER: Exhibit 4.

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MS. SINGER: Okay.
BY MS. SINGER:
Q. All right. Exhibit 4, if you could pull that one back out, please. If you could look in the middle of the page here, "In exclusion criteria, Dr. Wright suggested we have an exclusion such as: patient excluded if he/she has satisfactory management of pain with full dose NSAID."
Do you see where I am?
A. No.
Q. It's right in the middle.
A. Which page?
Q. I'm sorry, it is Bates number 185.
A. 185. Okay. Thank you. So it's that paragraph "In exclusion criteria."
MS. SINGER: Can whoever on the phone be on mute, please? We're getting a lot of background noise.
A. I see what you refer to.
Q. Okay. And do you recall that conversation?
A. No, I do not.
Q. Okay. And is it accurate to say your view was that patients who were doing well on

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NSAIDs should be excluded from a start on OxyContin?
MR. SNAPP: Object to the form.
A. It wasn't my view. It was the WHO analgesic ladder at the time.
BY MS. SINGER:
Q. And can you explain that?
A. The World Health Organization had some guidelines for pain management, and that was -- we called it the WHO ladder, and it was intended to guide physicians --
MS. SINGER: Excuse me, Dr. Wright.
On the phone, please mute. You're interrupting the deposition.
A. And the goal of it was to increase the likelihood that the patients' benefits outweighed the risks or adverse events. And WHO ladder has been subject to much controversy in the pain management community, but it basically is start with non-opioid drugs, add opioid drugs, then go to the heavy opioid drugs.
BY MS. SINGER:
Q. And in terms of your views, does that seem like the right approach?
MR. PETRILLO: Today?

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A. Today, then, whenever?
BY MS. SINGER:
Q. Why don't we start with today.
A. Okay. As modified by who the patient is and what their condition is. Ladders of that type, stepped care paradigms, were extremely popular back in the '70s and '80s, first do this, then do this, then do this, then do this. There was some controlled studies, which I can't cite, I'm sorry, that showed that when physicians were allowed to modify those stepped care protocols the outcomes were better, because if you had a patient who had mild osteoarthritis you would start with a non-steroidal. But if you had a patient who had two knees that were so damaged they couldn't walk, you wouldn't start with -- necessarily start with a non-steroidal in that case.
Q. So again, please correct me because I don't want to put words in your mouth, the stepped ladder provides a baseline that should be your starting guidepost, but you can vary from that for particular patients where warranted. Is that accurate as to your views?
A. Could you repeat that again?

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Q. No. But I can read it back.
A. Okay.
Q. Which is, correct me because I don't want to put words in your mouth, the stepped ladder provides a baseline that should be your starting guidepost, but you can vary from that for particular patients where warranted?
A. With a change. The general approach in that period of time was to start with the WHO ladder and modify as necessary to meet the needs of your individual patient.
Q. Okay. And is that your view now or then?
MR. SNAPP: Object to the form.
A. I decline to answer because there's been an enormous amount of research in the use of opioids for pain since that time, and I am not familiar with all of that research and what their findings have been. In general I still remain convinced that you should start with the drug with the least risk and move up toward the riskier drugs if you need them.
BY MS. SINGER:
Q. Okay. And the riskier drugs would be the opioids?

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MR. SNAPP: Object to the form.
A. Not exactly. There are -- there's -- there are patients for whom NSAIDs are much riskier than opioids, and NSAIDs are subject to dose duration limits that opioids are not. People treat -- you're asking fairly sophisticated medical management questions. There are patients for whom NSAIDs are very toxic indeed. There are patients for whom opioids are high risk indeed. And your goal, if you were a thoughtful physician, is to try to evaluate each single patient and say how can I manage their pain with the best chance of getting them relief and the least chance of hurting them or others.
BY MS. SINGER:
Q. And again, just to make sure I understand you, the idea is that the WHO ladder is a guideline, you start with NSAIDs, you move up the ladder to opioids, recognizing that for some patients NSAIDs may not be the right choice, and for patients with more severe conditions opioids may be the right choice?
MR. SNAPP: Object to the form.
A. There's not uniformity of medical

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opinion on this topic, because it depends on what the pain disease -- what pain condition you're treating. Some respond to NSAIDs beautifully, some don't respond to opioids at all.
And so the WHO guidelines were rough general guidelines that said here's a framework that you can hold on to, and you need to then modify it as you need to to practice medicine properly.
BY MS. SINGER:
Q. Okay. On the same exhibit, it says -- sorry. Let's leave this one for now. Actually sorry, let me see it again. All right. Let's turn to 563, please.
So this is Exhibit 9. It is PKY180919563, it's titled "Investigator's Brochure."
Dr. Wright, do you recognize this document?
(Whereupon, Purdue-Wright-9 was marked for identification.)
A. No, I do not.
BY MS. SINGER:
Q. Okay. Do you know what an

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investigator's brochure is?
A. Yes.
Q. Okay. What is an investigator's brochure?
A. An investigator's brochure is a statement of what is known about the investigational drug up to the point of the start of the study, or sometimes beyond if it's a long study, which is provided to the investigator so that the investigator knows everything that the company knows or thinks it knows or hopes it knows about the investigational drug before they decide to enroll a patient in the study.
Q. Okay. And just to be clear, it's a document provided by the company, the drug sponsor, to the FDA, correct?
A. It is -- the IND should include a copy of the investigator's brochure.
Q. Okay. Which, again, is from the company to the FDA?
A. Yes.
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Okay. So if you can turn to Bates

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number 598, please. Now, I'm sorry just to locate this document, it's titled "Oral Controlled-Release Oxycodone Hydrochloride Tablets" on the title page, correct?
A. Oral Controlled-Release Oxycodone Hydrochloride Tablets.
Q. Under the title "OxyContin" which is probably more descriptive?
A. Yes.
Q. So this is the investigator's brochure for OxyContin, correct?
A. It appears to be.
Q. I'm sorry, now let's go to 598, please. If you can look at the section under "Abuse Liability of Oxycodone," please. And if you look down, second paragraph, "The abuse and illegal drug trafficking," and just read that to yourself, please.
(Witness reviewing document.)
BY MS. SINGER:
Q. Just let me know whenever you're ready.
And do you read this to talk about prior diversion and abuse of Percodan?
A. I read this as a discussion of the

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abuse and diversion of Percodan.
Q. Okay. Which came from, according to Purdue's report, "a liberal regulation of oxycodone-containing compounds whereby 'street' addicts could obtain Percodan more easily than morphine," correct?
MR. SNAPP: Object to the form.
A. That's what it says.
BY MS. SINGER:
Q. Okay. And that "Percodan was easily boiled into a solution by the 'street' addict and strained for injection," correct?
A. Yes.
Q. Okay. And this is knowledge that Purdue submitted to the FDA, correct?
MR. SNAPP: Object to the form.
A. Yes.
BY MS. SINGER:
Q. Yes, it was poorly worded.
This document reflects Purdue's statement to the FDA about that history with Percodan, correct?
A. No. This statement refers to Purdue's statement to the investigators, a copy of which is provided to the FDA.

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Q. Okay. And who are the investigators?
A. The people who conduct the clinical studies for Purdue.
Q. Got it. Okay.
All right. So it is Purdue's statement to the investigators doing the clinical trials and to the FDA which receives a copy, correct?
MR. SNAPP: Object to the form.
A. (Nodding in the affirmative).
BY MS. SINGER:
Q. You nodded.
A. I nodded. This document should have been provided to every investigator who conducted a Purdue clinical trial, and a copy should have been submitted to the IND.
Q. Okay. By Purdue, correct?
A. By Purdue.
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Okay. And on Page 599, the top of the next page, if you can look at the bottom sentence of the partial paragraph that starts the page, "Furthermore, other studies have shown that the incidence of iatrogenic addition to

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opioid analgesics is very low (see subsequent discussion)."
Do you see that?
A. Yes.
Q. Okay. And if you move down the page, "The incidence of narcotic addiction," very last paragraph, "was obtained by the Boston Collaborative Drug Surveillance Program from their files on 39,946 hospitalized patients," and it cites Porter and Jick, 1980.
Are you familiar with that study?
A. I'm familiar with the name, and I've looked at it in the past. I can't recall the details of it at this time.
Q. Okay. Do you recall that it was a letter to the editor?
MR. SNAPP: Object to the form.
A. That sounds familiar.
BY MS. SINGER:
Q. Okay. And do you recall that it was review of hospitalized patients?
A. Yes.
Q. Okay. All right. Move on.
(Whereupon, Purdue-Wright-10 was marked for identification.)

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BY MS. SINGER:
Q. Exhibit 10 is PKY181876119, and it is titled "Regulatory Barriers to Effective Pain Management."
I take it you don't recall having seen this document, is that correct?
A. No, I don't remember this document at all.
Q. Okay. Do you recognize the name R. Kaiko?
A. Bob Kaiko.
Q. Kaiko.
A. Yes, Bob Kaiko was a scientist at Purdue.
Q. What about M. Innaurato?
A. I have heard the name. I can't place it with a face, and I don't know what he did.
Q. Okay. I want to direct you, if I might, to Bates number 258 -- I'm sorry, actually 257, which I think in the PKY is 120.
And the last paragraph talks about "Perhaps even more importantly, with the movement of our scheduled analgesics to non-cancer pain (with the introduction of DHCplus and the coming introduction of

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OxyContin), we cannot help but believe these regulatory and legal barriers will pose substantial impediments."
Do you see where I've read?
A. Yes.
Q. Do you recall Purdue ever talking to you about moving OxyContin into the non-cancer pain patient?
MR. SNAPP: Object to the form.
A. I don't remember Purdue talking about that as a goal for OxyContin.
BY MS. SINGER:
Q. And did you ever become aware of that as a goal for OxyContin?
MR. SNAPP: Object to the form.
A. Ever. In some of the previous documents it -- I never looked -- I never formulated it that way, I never -- I just don't know.
BY MS. SINGER:
Q. And if you didn't formulate it that way, was there a different way that you formulated it?
A. If these documents --
MR. SNAPP: Object to the form.

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A. If these documents are accurate, I made it very clear that we didn't want to see narcotics as the primary therapy for unselected patients with osteoarthritis. We didn't want to see an osteoarthritis indication.
(Whereupon, Purdue-Wright-11 was marked for identification.)
BY MS. SINGER:
Q. We're at Exhibit 11, PKY180723482, titled Project Team Contact. We've done this one. That's my fault. We've done this one. My apologies. Let's go to 232.
(Whereupon, Purdue-Wright-12 was marked for identification.)
BY MS. SINGER:
Q. So Exhibit 11 is going to be blank, and we'll just move to Exhibit 12. And that is PDD1701503232 titled Meeting Minutes.
And, Dr. Wright, do you see your name listed as an FDA representative?
A. Yes, I do.
Q. Okay. And do you have any recollection of a June 23rd, '93, 1993, meeting with Purdue?
A. I don't have any recollection

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immediately. I'm trying to see if this refreshes my recollection.
Q. Okay.
(Witness reviewing document.)
Q. If it's helpful, I can direct you to a particular piece of this and see if that refreshes your recollection. So if you want to go, please, to Bates number 238. And if you look at Section 2, "Nonclinical Toxicology."
Do you see where that is?
A. (Nodding in the affirmative).
Q. It says here that "It was also agreed that oxycodone is an old drug in which the human toxicity profile is well-known."
Do you see that sentence?
MR. SNAPP: Object to the form.
A. Yes, I see that.
BY MS. SINGER:
Q. And do you agree with that statement that "oxycodone is an old drug in which the human toxicity profile is well-known"?
A. Agree now, or agreed then?
Q. Start with now.
A. I agree.
Q. And did you agree back in 1993 when

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this meeting happened?
MR. SNAPP: Object to the form.
MR. PETRILLO: Just for the record, it doesn't appear that at this portion of the meeting Dr. Wright was present, according to the minutes.
A. I don't remember the meeting, and I don't know whether I was present or not. You were asking an independent question from my clinical opinion.
BY MS. SINGER:
Q. That's right.
A. Both then and now I believe the toxicity profile of oxycodone is well-known.
Q. And do you believe that that's true at all of the different dosage forms of oxycodone?
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Meaning, in 1993 was the human toxicity profile of OxyContin at 40 milligrams well-known?
MR. SNAPP: Object to the form.
A. In -- I'm still not understanding what is it that you want to know.
BY MS. SINGER:

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Q. Whether there was a body of knowledge or evidence about the toxicology of OxyContin at 40 milligrams when the drug was submitted for approval.
MR. SNAPP: Object to the form.
A. I certainly believed so at the time.
BY MS. SINGER:
Q. And do you believe that now?
A. I don't know, because circumstances have changed between then and now.
Q. In what way?
MR. SNAPP: Object to the form.
A. Well, a lot of ways. But in 1980, '85, '90, the focus of safety as defined by the agency for a pharmaceutical was safety used as directed by a medical practitioner. The notion of pharmacoepidemiology, what are the safety results in the population as vended and sold by the population, was emerging but was not a fully developed principle then, I don't think the guidances on pharmacovigilance and pharmacoepidemiology were fully developed then. I don't know for sure what the timing was.
Today, by today's standards, what happens when the drug interacts with a specific

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population matters and is considered as part of the safety profile for a new drug. At the time I remember being concerned about abuse of OxyContin, we all were, but we had no notion that the society had changed to the point where the 40 and the 80-milligram OxyContin products would be so desirable for purposes of diversion.
I don't know if that's a long painful answer to what you had to say. Oxycodone we knew about. We knew what oxycodone safety was like and what was likely to happen. OxyContin, the drug product as marketed, we weren't thinking that way in 1990, '95.
BY MS. SINGER:
Q. Okay. If we can go back to Exhibit 12 for a moment, that's the one that's 232, maybe the one we have right now. And if you could turn to Bates number 239, which is the next page from where we were, and if you could look under Paragraph 3, "Toxicology of Abuse."
Do you see that at the top of the page?
A. Mm-hmm.
Q. And could you read that first sentence, please?

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A. "Toxicology of Abuse: The FDA was concerned about pulmonary microemboli and granulomas which may occur when oral preparations such as this are extracted and injected intravenously by abusers."
Q. You can stop there, just the first sentence.
Do you recall having this conversation with Purdue Pharma?
A. Vaguely. We always were concerned about excipients.
Q. About?
A. Excipients.
Q. And can you explain what that is?
A. There were some products, and I cannot remember their names, they were narcotics, where the company used a binder for the tablets that contained a variety of foreign materials called excipients which held the tablet together. Talc in particular was particularly problematic because if it was injected intravenously it could cause significant granulomatous damage to the lungs of abusers.
Q. Okay. So this reflects that the FDA was talking to Purdue Pharma back in 1993 about

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the risks associated with injection of OxyContin, is that correct?
MR. SNAPP: Object to the form.
A. It was -- yes, I think so.
BY MS. SINGER:
Q. Okay. And did the extended-release, the controlled-release profile of OxyContin have any impact on how the FDA or how you, how you, assessed the risk or likelihood that users would inject OxyContin?
MR. SNAPP: Object to the form.
A. Can you sharpen that up a little bit? Because that is such a -- "have any," that is such a vague question.
BY MS. SINGER:
Q. Did you think that the controlled-release formulation would make it more attractive for users to inject OxyContin?
A. I did not think that the controlled-release formulation would make the product more attractive. We were concerned about the tablet size.
Q. Okay. What about the potency of the tablets, did you think that would have any impact on the likelihood of intravenous use?

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A. I'm confused --
MR. SNAPP: Object to the form.
A. -- because you used the word "potency." That has a specific technical meaning.
BY MS. SINGER:
Q. Which I'm sure I didn't intend.
A. We were concerned about the amount of drug in the tablet. A lot of drug in a tablet.
Q. Okay.
A. Make it attractive, a lot of drug.
Q. And is there a lot of drug at 80 milligrams of OxyContin?
A. There is a lot of drug --
MR. SNAPP: Object to the form.
A. -- at 80 milligrams of OxyContin, 80 milligrams.
BY MS. SINGER:
Q. And is there a lot at 40 milligrams?
MR. SNAPP: Object to the form.
A. Immediate-release opioids of the period had 5, maybe 10 milligrams. 40 milligrams is four times as much.
BY MS. SINGER:
Q. Is it enough to produce euphoria --

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MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. -- when injected?
A. That is so hard to answer, because it depends on the state of opioid tolerance of the individual. But for a naive user who has not had any opioids, injecting 40 milligrams or 80 milligrams of oxycodone would be a very strong dose, very strong, and severe.
Q. All right. And moving to the next paragraph which is somewhat bolded, "As part of the June 30 telephone conversation" -- do you see where I am on 239, Dr. Hayes -- "between Dr. Hayes and Dr. Tigner"?
A. Mm-hmm.
Q. "It was agreed that oxycodone HCl" -- is that OxyContin.
A. That's oxycodone hydrochloride, the parent drug substance.
Q. Okay.
-- "is very soluble in water, a fact which abusers would most likely learn very quickly."
Do you remember this conversation -- did you ever hear about this conversation?

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A. I don't remember whether I heard about it or not.
Q. And are you aware of the water solubility of oxycodone hydrochloride?
A. Very much so.
Q. And was that something that you thought about and discussed with Purdue Pharma at the time?
MR. SNAPP: Object to the form.
A. I don't know if I discussed it or not, because all drugs of that class that I know of, the semi-synthetic narcotics of that era and age, are water soluble, that they were developed to be water soluble. Did I discuss with -- the fact with Purdue that their drug could be cooked and shot, injected for abuse? I'm almost certain I didn't.
BY MS. SINGER:
Q. Okay. All right. If we could turn to Bates number 3241, also the top of the page.
A. 3241?
Q. 3241. It's the next page, I think. You'll see Paragraph 6, "Higher Dosage Strengths - Adverse Event Profile Concerns." And can you read aloud through "opioid tolerant patients

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only"? So the first two sentences, I believe.
A. "Because oxycodone IR 5 milligrams is the current marketed product there is concern about the adverse event profile of higher dosage strengths (40, 80, 160) are administered to opiate naive patients. Suggestion that PF consider including a 'red triangle (opioid tolerant only)' on the packaging of the 40, 80 and 160-milligram dosage strengths to indicate that these dosage strengths be administered to opioid tolerant patients only."
Q. You can stop there.
Do you remember that conversation?
A. Not specifically, but I remember the red triangle.
Q. And what do you remember about that?
A. Okay. It was what we negotiated and was launched under gesic, I mentioned earlier in the discussion that we wanted some kind of distinctive marking hopefully common across manufacturers that indicated to prescribers that this was a high strength.
Q. Okay. And what were your concerns at higher dose strengths?
A. There would -- that someone would

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overdose.
Q. And do you know as we sit here what the morphine equivalent dose of 40 milligrams of OxyContin taken twice a day as directed is?
A. Not anymore. I used to.
Q. Okay. And do you recall thinking that the 40, 80 and 160-milligram dosage strengths should have that red triangle?
MR. SNAPP: Object to the form.
A. I do not recall that specifically. This memorandum suggests that that's what I thought at the time.
BY MS. SINGER:
Q. And does that seem accurate and consistent with your beliefs?
A. Seems accurate and consistent with my beliefs. Somewhere -- and I don't know whether it would be 40 or 60 or whether it should just be the 80 and 160, I wasn't certain, but I knew that past a certain point those tablets should be only going into opioid tolerant patients.
Q. If we can move down on the same page to Paragraph 13, can you read what it says by "Combination Product"?
A. Yes. Would you like me to?

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Q. Yes. Please.
A. "Combination product: PF should consider an OxyContin Tablets/Naloxone combination as a supplement to the NDA."
Q. So do you recall this conversation with Purdue?
A. I don't recall it. I have no reason to think I didn't do it.
Q. Okay. And why would -- why would you have recommended to Purdue that it consider an OxyContin/naloxone combination?
MR. SNAPP: Object to the form.
A. It is clear -- it was clear to us then, it is clear to us now, it is clear to me now that this product was vulnerable to tampering and injection. If you made an oxycodone/naloxone combination, the naloxone would spoil the oxycodone by acting as an antagonist, and it could not be injected.
Looking back, based on my experience since that time, that was an easy thing to ask for and an extraordinarily difficult thing to do.
BY MS. SINGER:
Q. Understanding that, it certainly

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reflects an awareness back in 1993 that injection was going to be a problem, correct?
MR. SNAPP: Object to the form.
A. Is that a question?
BY MS. SINGER:
Q. Yes.
MR. SNAPP: Object to the form.
A. Okay. Could you restate it, please, simply?
BY MS. SINGER:
Q. Sure.
So the recommendation that Purdue consider an OxyContin/naloxone combination reflects a recognition that there was going to be use by injection?
MR. SNAPP: Object to the form.
A. It's still a statement, not a question.
BY MS. SINGER:
Q. Correct. Is that right?
MR. SNAPP: Object to the form.
A. From the earliest point through the final approval of oxycodone, OxyContin, there was never any illusions on the agency's part that this was a product that could develop an

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abuse problem. Never any question.
(Whereupon, Purdue-Wright-13 was marked for identification.)
BY MS. SINGER:
Q. So this is Exhibit 13, PDD 150 -- I'm sorry, SHC-00007028. And it is "Subject: FDA OxyContin Tablets Meeting."
Dr. Wright, are you familiar with this document?
A. I don't know that I've ever seen it.
Q. Okay. Do you see yourself listed among the FDA attendees on the first page?
A. Yes, I do.
Q. Okay. And can you see among the "To" line here that this memo was circulated to M.D. Sackler, R.R. Sackler, R.S. Sackler, K.A. Sackler, J.D. Sackler?
A. That's what the addressees say.
Q. From your time at Purdue, was it common to send the Sacklers information about FDA meetings?
MR. SNAPP: Object to the form.
A. I don't know what was sent to the Sacklers and what was not.
BY MS. SINGER:

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Q. Okay. Now, in the first paragraph on the first page below the tos and attendance lists, it describes the pilot division of the FDA and the NDA process, is that correct?
A. Yes.
Q. Okay. And was this pilot process different from other opioid approvals you'd been involved in before?
A. No.
Q. It was the same pilot process, is that correct?
A. Well, with a caveat. The goal of the pilot drug evaluation staff was to pilot new approaches to the review process to improve its quality and efficiency. So therefore, as we learned from one NDA to the next what worked and what didn't work, or there were technical changes in the technological environment so that we could do things that we couldn't do before, like use computers in the review process, use telecommunications for meetings instead of having them in face-by-face, we would incorporate that. So did it change over time? Yes. Was it the same process pretty much? Yes.
Q. Okay. And are you aware that, or is

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it correct that OxyContin was what's called a non-NME drug review?
A. Yes.
Q. Okay. And can you explain what that means?
A. There are -- there's no official difference between any of the kinds of applications that are sent into the agency except some of the more modern changes, but the agency broadly split as a matter of policy drugs into two classes. New molecular entities that had not been in man, that's an NME, or drugs that had been in man in some form and had an established toxicity record, non-NME.
Q. And was the level of scrutiny or the bar to approval different between NME and non-NME drugs?
A. Yes.
Q. In what way?
A. For a non-NME product you were looking to look for unanticipated adverse events at, say, the 1 percent level. For an NME you were looking at -- trying to look at, say, the tenth of a percent level, you needed more patients, longer studies, more time, more toxicology,

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ancillary studies of several different kinds to look for unusual or unanticipated toxicity. An example would be that there's now screening for certain kinds of cardiac effects that did not exist at this time.
So an NME gets a lot longer period of scrutiny, a lot longer period of tests, and a lot more patients in the NDA.
Q. So we can just do one more document, and then if it's a good time to break for lunch.
(Whereupon, Purdue-Wright-14 was marked for identification.)
BY MS. SINGER:
Q. So Exhibit 14 is PDD1501090043 titled "Medical Officer Review." And do you recognize this document?
A. This looks like my medical officer summary review of OxyContin.
Q. Okay. And you're listed as the reviewer, correct?
A. I'm listed as the reviewer in this one.
Q. Okay. So if you can turn to -- I'm sorry, the first page, so it starts halfway down -- or it doesn't start, but halfway down the

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first page where it says "Background. Oxycodone is an old opioid that's been on the market for many years in pre-38, USP, brand and generic immediate-release forms as a QID drug both singly and in fixed combinations with NSAIDs."

So could you explain that sentence, unpack some of those acronyms, please? So pre-38.

A. Pre-38, it was on -- some form of it was on the market prior to 1938.

Q. Okay. And USP?

A. The USP has a US Pharmacopeia standard for the drug for purity and potency.

Q. And so there's been both brand and generic versions, correct?

A. It says brand and generic.

Q. And then a QID drug?

A. Four times a day.

Q. And then "singly and in fixed combinations of NSAIDs" mean that they're both single entity opioids and then combination opioids, correct?

A. That was my understanding at the time.

Q. Okay. So what you're saying here, and again correct me as I know you will, that this

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is a drug that's been around for decades?

MR. SNAPP: Object to the form.

BY MS. SINGER:

Q. Correct?

A. This is a drug that has been around for decades.

Q. Okay. And let's turn to Bates number 45, so the next page. The first paragraph of text, "Both treatments appear to be similar with respect to peak, trough, mean and extreme values in clinical populations."

Do you see where I'm reading?

A. Yes, ma'am.

Q. Okay. So both treatments, can you explain what that's referring to?

A. Immediate-release and controlled-release oxycodone given in these doses appeared to have similar peak and trough concentrations.

Q. Okay. And those are the words we talked about earlier, and what they mean in terms of their significance?

A. Those are words we've talked about earlier.

Q. Okay. And extreme values?

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MR. SNAPP: Object to the form.

BY MS. SINGER:

Q. What does that mean?

A. What is an extreme value? When you're doing a pharmacokinetic study and you're giving the drug to individuals, some people will on some occasions for some reason that we don't understand have an extremely high value or an extremely low value. You look at those because the extremely low value suggests the drug would not be working. And the extremely high value suggests that the drug would be working too well.

Q. Okay. And so can you explain -- what you're saying in this sentence for the layperson is that the peak trough, middle, and outliers are relatively similar between immediate-release and extended-release oxycodone?

MR. SNAPP: Object to the form.

A. What I'm saying at this point is the peak trough and outliers appeared to be similar.

BY MS. SINGER:

Q. Okay. And then if we can turn to Page 56, or Bates number 56.

MS. SINGER: I have an extra copy if

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somebody wants it (handing).

Q. Do you see the section titled "Rescue Use (Supplemental Analgesic)"?

A. What page again?

Q. Bates number 56, very last page.

A. Yes. I see it.

Q. And before I ask you about that, do you recall what the dosing is for OxyContin?

MR. SNAPP: Object to the form.

A. I'd have to refer to the package insert.

BY MS. SINGER:

Q. Okay. It may say so here.

All right. So you can see the last paragraph, "Overall Conclusion," can you read the last sentence? And you can read it out loud.

A. "This product has been shown to be as good as current therapy, bu has not been shown to have a significant advantage beyond reduction in frequency of dosing."

Q. And do you remember coming to that conclusion?

A. I don't remember it independently, but I have no reason to doubt that I wrote this.

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Q. Okay. Okay. And would it refresh your recollection, and if it doesn't it doesn't, that OxyContin is a 12-hour drug?
MR. SNAPP: Object to the form.
A. That's what it says here, BID drug.
BY MS. SINGER:
Q. BID. There you have it.
What does BID stand for?
A. Twice a day, 12 hours.
Q. So if you go back to Rescue Use, it indicates at the last sentence there "Patients used about 1 to 2 doses of rescue a day and found it an important part of therapy."
Do you see where I'm reading?
A. Yes.
Q. What is a rescue dose?
A. Okay. A rescue dose of an immediate-release analgesic, or any analgesic, is used when the quality of pain control has become unacceptable. If you give somebody -- in general, this is what I was taught. If you give somebody enough analgesic so that they never have pain during the day, then there will be times during the day when they are inappropriately narcotized. So it is considered

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a normal part of round-the-clock opioid therapy to have both your round-the-clock drug and then during episodes of breakthrough pain, which can occur with toileting, mobility, having to get in the car or out of the car to go to the hospital, anything that might happen, you then can give the immediate-release as part of the breakthrough, as part of the treatment.
Q. Okay. I think that's all I have.
MS. SINGER: We can take a break.
THE VIDEOGRAPHER: We are now going off the record, and the time is 12:39.
(Whereupon, a luncheon recess was taken.)

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AFTERNOON SESSION

THE VIDEOGRAPHER: We are now going back on the record, and the time is 1:30 p.m.
BY MS. SINGER:
Q. All right. Dr. Wright, I'm just reminding you you're still under oath as we resume. And we'll start with Exhibit 15.
(Whereupon, Purdue-Wright-15 was marked for identification.)
BY MS. SINGER:
Q. So Exhibit 15 is Bates number SHC-8168 and it's titled "Project Team Contact Report."
Is this document familiar to you, Dr. Wright?
A. I don't recognize this document.
Q. Okay. It indicates that it is the record of a contact between Dr. Reder from Purdue and you at FDA.
Does that seem right?
A. That's what it says.
Q. Okay. And if you could take a moment, the reason for the call indicates "Discuss OC93-0704 - Package Insert Testing Study."
Do you recall the package insert

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testing study?
A. I don't remember it at this time. I know what package insert testing studies are.
Q. And what are they?
A. It's where you take physicians who are likely to prescribe the product and you give them the package insert, and then you ask them relevant questions about using the product.
Q. Okay. And that goes back to, I think, and correct me if I'm wrong, your point earlier that the goal of the package insert is to inform prescribers about the uses, risks, benefits, administration, all of those aspects of a prescription drug, is that correct?
MR. SNAPP: Object to the form.
A. Do you wish me to restate it?
BY MS. SINGER:
Q. Either agree with it or put it in words that you can agree to.
A. The package insert informs physicians how to use the product.
Q. Okay. And it says here -- and this relates to OxyContin, correct?
A. It's an OC number, so that would be the OxyContin.

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Q. And can you read what it says about the package insert testing study under the "Results of a recent study showed"?
A. "One half of the physicians did not dose according to the package insert. 98 percent of the physicians ignored some of the precautionary information in the package insert. And a previously unrecognized disease/treatment interaction was seen."
Q. Go ahead, if you can finish out that last sentence.
A. "Because of our substantial database, Dr. Wright would not anticipate major new findings but asked that we continue the program for now."
Q. Okay. So does this refresh your recollection about this, conversation or this study?
A. It does not.
Q. Okay. Do you have any reason to believe that that is not an accurate report about that study?
MR. SNAPP: Object to the form.
A. I can't really say whether it's accurate or not. There are -- contact reports

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in the company report what the person on the company side heard. I don't know what I said.
BY MS. SINGER:
Q. Although isn't this a report on a study that Purdue conducted?
A. Yes.
Q. Okay. So --
A. Since I don't remember the conversation, and I don't, I can't say whether his characterization of my response is accurate or inaccurate.
Q. Okay. So other than his characterization of your response, do you have any reason to disbelieve the account of the package insert testing study that's included here?
MR. SNAPP: Object to the form.
A. I have no reason to doubt that.
BY MS. SINGER:
Q. Okay. Do you know if this is a high rate of non-compliance with the package insert?
MR. SNAPP: Object to the form.
A. It's been too long since I looked at these. Non-compliance with a package insert was extremely common. Sometimes it was pernicious,

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sometimes it was not. To understand this, I'd have to know what the non-compliance was, and if it posed a threat to patients.
BY MS. SINGER:
Q. Okay. So we're going to go back, I think it's Exhibit 4, but I'm just guessing. 14, sorry, Exhibit 14. Your medical officer report.
A. It's half the medical officer report, I think.
Q. And do you want to explain what you mean by that? This is the report relating to --
A. This is the integrated summary of efficacy. There should be somewhere a integrated summary of safety.
Q. Okay. I want to return to the last page of the document, 056, I think you read this earlier. But you wrote, "Care should be taken to limit competitive promotion."
Have I read that accurately?
A. Yes, ma'am.
Q. And that was your conclusion?
A. Yes, ma'am.
Q. And finishing, I'm sorry, the next sentence, "This product has been shown to be as

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good as current therapy, but has not been shown to have a significant advantage beyond reduction in frequency of dosing," correct?
A. That's what it says.
Q. And that's what you wrote?
A. I'm pretty sure that's what I wrote. It wasn't just me, that would have been me and Doug Kramer at that point. And I don't know if this underwent another peer review, I just don't remember, but it was two or three of us.
Q. Okay. And is this the same Doug Kramer who was later at Purdue Pharma with you?
A. Yes.
Q. And so when you say no significant -- "has not been shown to have a significant advantage beyond reduction in frequency of dosing," that means no reduction in adverse effects, correct?
MR. SNAPP: Object to the form.
A. I'd have to look at the integrated summary of safety to reach that conclusion. But it says what it says, it's not any better than conventional therapy.
BY MS. SINGER:
Q. Okay. So when you say "competitive

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promotion," should take care not to engage in competitive promotion, that means that, consistent with your medical officer review or the medical officer review which you co-authored or participated in, Purdue could not represent that OxyContin was more effective than other opioids, is that correct?

MR. SNAPP: Object to the form.

A. Based on the document that I see, what that kind of language usually means is a signal for DDMAC, for the division of drug advertising, that since OxyContin was not tested against other similar analgesics and shown to be better, you can't make claims that it's better than other opioid analgesics.

BY MS. SINGER:

Q. Okay. And would that include that it was less likely to be abused than other opioid analgesics?

MR. SNAPP: Object to the form.

A. That's a -- you asked a difficult question because it doesn't have a yes or no answer. At that time controlled-release dosage forms which had a slower upsweep and onset were viewed to pose less risk of dependence or abuse

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than immediate-release dosage forms. But that is, in general, a safety issue, and there is great reluctance to allow promotion on safety unless there is a definitive proved safety advantage.

BY MS. SINGER:

Q. Okay. And is there anything in your memory or the medical officer report that indicates that OxyContin -- that Purdue had demonstrated that OxyContin had a proved safety advantage?

MR. SNAPP: Object to the form.

MR. PETRILLO: Objection.

A. I'd have to look at the integrated summary of safety before I could answer that.

BY MS. SINGER:

Q. All right. We'll try to pull that out.

A. Okay.

Q. Okay. This is going to be taxing to read, but this is Exhibit 16.

(Whereupon, Purdue-Wright-16 was marked for identification.)

BY MS. SINGER:

Q. It's PKY183226682. Do you recognize

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this document, Dr. Wright?

A. It looks like an OxyContin package insert, which version I don't know.

Q. And if you could look at the middle column, and I have to get up close to see it -- sorry. Okay. We're actually going to go to Bates number 687, please. All right. If you look in the middle column under the heading "Drug Abuse and Dependence."

Do you see where I'm reading?

A. Yes, ma'am.

Q. Okay. And can you read aloud the last sentence, "Delayed absorption"?

MR. PETRILLO: Last sentence, first paragraph?

MS. SINGER: Of that first paragraph, "Delayed absorption, as provided by OxyContin tablets."

A. "Delayed absorption, as provided by OxyContin tablets, is believed to reduce the abuse liability of a drug."

BY MS. SINGER:

Q. Okay. Do you know who proposed that language?

A. I don't know.

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Q. Okay. All right. Exhibit 17.

(Whereupon, Purdue-Wright-17 was marked for identification.)

BY MS. SINGER:

Q. Is SHC-4520, it's titled on the first page "8/2/95 Reder."

A. Mm-hmm.

Q. Do you recognize that to be how Robert Reder spelled his name?

A. I thought there were two E's.

Q. Okay. All right. Do you see on 4521, the next page on the top it says "Reder Version"?

A. "Reder Version."

Q. Okay. Have you ever seen this version of the package insert before?

A. I can't remember.

Q. Okay. And I just want you to turn the page to 4522, please. Do you recognize that handwriting? And you can page through the document and see if the handwriting is familiar to you.

A. I don't know who that is.

Q. Is it your handwriting?

A. No, it is not.

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Q. Okay. And so if we can turn to Bates number 4538, and can you see at line 580 there's some handwritten text on the right margin?
A. Mm-hmm.
Q. And can you read, I know it's not easy, can you decipher what is written there? If you can't, I can do my best.
A. "Delayed new opioid activity as provided by OxyContin tablets is believed to reduce the abuse liability of a drug."
Q. Okay. Do you recall ever proposing that language to Robert Reder?
A. I don't remember specifically doing so, but I could have.
Q. Do you recall instances in which you proposed or dictated language to Dr. Reder?
MR. SNAPP: Object to the form.
A. I recall instances in conferences with sponsors that I have proposed language. I don't know what I proposed to Robert or not.
BY MS. SINGER:
Q. Or whether?
A. Or whether.
Q. Okay. But you're certain this is not your handwriting?

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MR. PETRILLO: Form.
A. No, that is not my handwriting.
BY MS. SINGER:
Q. Okay. We're going to return to Exhibit 14, or not. Yes. So if you can turn to Bates number 055.
A. I'm having trouble finding 14.
MR. PETRILLO: Sorry. Let's see. Here you go.
A. And 055?
BY MS. SINGER:
Q. 055. And can you read out loud the first sentence?
A. "There is a theoretical possibility that the slower fall and slightly higher trough might result in greater development of tolerance and/or withdrawal phenomenon. This was not seen in the database (see ISS), and the two daily troughs appear adequate based on the divisional experience with 'trough-less' opioid dosage forms such as Duragesic."
Q. What was the basis of that theoretical possibility? What gave rise to that possibility?
MR. SNAPP: Object to the form.

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A. During my -- I'm having to reconstruct what I might have thought at the time, is that okay?
BY MS. SINGER:
Q. Absolutely.
A. During my postdoctoral fellowship I looked -- I was doing research and reviewed the literature on the development of tolerance to opioids. Tolerance is a defensive reaction by the body to administration of opioids, and it develops in everybody who takes an opioid, who has experienced an opioid effect, and it occurs at different speeds depending upon most likely the area under the curve of the concentration exposure time. The longer the drug is in and the higher the level of the drug, the more tolerance you get. Changing the pharmacokinetic profile from up, down, up, down, up, down to up, down, up, down could theoretically alter the development of tolerance.
Q. And do you know in what direction it would alter the development of tolerance, if it did?
MR. SNAPP: Object to the form.
A. A longer apparent half-life would be

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likely to increase the development of tolerance, which is a good thing.
BY MS. SINGER:
Q. Okay. And when you talked about the development of tolerance, you talked about the area under the curve as duration, I think, and --
A. Plasma concentration, time. So its units are time and -- plasma concentration and time.
Q. And does plasma concentration relate to the dose?
A. Yes.
Q. Meaning the higher the dose --
A. The higher the plasma concentration. Bigger doses should give a higher plasma concentration.
Q. And thus, yield more tolerance, correct?
A. Yes.
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. So Exhibit 18.
(Whereupon, Purdue-Wright-18 was marked for identification.)

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BY MS. SINGER:
Q. Which is PKY180715570. If you turn to the second page, 571, you'll see its title, "OxyContin Meeting, April 23, 2001." And certainly take a moment to look through it, but what I'd like you to tell me is whether this seems to reflect the summary of a meeting between Purdue Pharma, the FDA -- sorry, Purdue Pharma and the FDA.
(Witness reviewing document.)
A. This appears to reflect minutes of a meeting held between the FDA and Purdue Pharma.
Q. Okay. And you're not listed as an attendee at this meeting, correct?
A. I am not listed as an attendee.
Q. But if you look at the stamp on Bates number 571, do you see a Received stamp?
A. I do.
Q. Does that indicate "Received May 14, 2001, Curt Wright"?
A. Yes, it does.
Q. And does that reflect a stamp that was put on correspondence when you received it?
A. I don't remember having correspondence stamped when I received it.

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Q. Could it be anyone else's?
A. I don't know who stamped it and why my name is on it. I don't really know.
Q. Okay. Do you go by Curt?
A. No. I usually -- in the work environment I'm usually Curtis. My full name is Curtis Wright. I don't remember ever seeing a stamp that looked like that before.
Q. Okay. Do you remember receiving this document?
A. No, I don't.
Q. Do you remember hearing about a meeting between Purdue and the FDA in April, 2001 at which concerns about OxyContin were discussed?
MR. SNAPP: Object to the form.
A. I don't -- I was not kept very well informed, nor should I have been not being on the OxyContin team, of what was happening with the FDA. The only time I found out about it was when somebody asked me some question.
BY MS. SINGER:
Q. Okay. Okay. Let's turn, and we'll talk about this from your experience, but -- sorry, too many pages. All right. If we can

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start with Bates number 572, please.
A. Yes.
Q. Okay. Do you know Dr. McCormick?
A. She was my division director for a brief period of time. I was her deputy in my last few months at the FDA.
Q. Okay. And so if you look down, so third paragraph you see Dr. Pollock listed. Do you remember, or did you know Dr. Pollock?
A. I don't remember ever meeting Dr. Pollock.
Q. Okay. At the bottom of that third paragraph with Dr. Pollock, it notes that MS Contin prescribing had remained relatively constant, but OxyContin had increased ten fold.
Was that -- do you know that to be true, or is it consistent with your understanding of what happened to the sales of MS Contin and OxyContin?
MR. SNAPP: Object to the form.
A. To be strictly accurate I'd have to look at the data. Sales of OxyContin did increase at some point during this period quite a bit.
BY MS. SINGER:

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Q. Okay. And then the next paragraph talks about Dr. Hertz. Did you work with Dr. Hertz?
A. No.
Q. And do you know who she is?
A. She -- I think at this point she was on her way to becoming deputy director of the division.
Q. Which division is that?
A. The analgesic division.
Q. At FDA?
A. At FDA.
Q. Okay. And it says here "OxyContin is not necessarily the first opioid to be used and it should not be an intermittent opioid."
Do you see that sentence?
A. Yes.
Q. And is that consistent with what you were saying earlier about it being not necessarily appropriate for all patients in the first instance?
MR. SNAPP: Object to the form.
A. Since it's somebody else's comment I can just say whether I agree with it or not. I agree with "OxyContin is not necessarily the

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first opioid to be used and it should not be used as an intermittent opioid."
BY MS. SINGER:
Q. Okay. All right. And then if you go down to the last paragraph, "She would also like to see educational efforts increased including possibly a Medguide for patients on the risks of overdose and the abuse of opioids as well as risks for use by others than whom it was prescribed."
Were you aware that that recommendation was made to Purdue?
A. If I was, I certainly don't remember it now.
Q. Okay. And sitting here, do you agree that that was a step that Purdue should have considered --
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. -- in 2001?
MR. SNAPP: Object to the form.
A. If it's recommended by a senior physician in the FDA, you certainly should consider it.
BY MS. SINGER:

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Q. And given your knowledge of abuse and adverse effects from the abuse of an addiction to OxyContin, does that also strike you as a prudent recommendation?
MR. SNAPP: Object to the form.
A. It's amazing -- it's very difficult to be -- to object to a well written, useful med guide. When you initiate a med guide is really an agency decision. I don't know of -- well, I'm not familiar with writing a -- going through the expense of writing a med guide voluntarily. But a med guide is one of the first things the agency pulls out of its toolbox when it perceives an emerging problem.
BY MS. SINGER:
Q. And then if you look at Bates number 574, Paragraph 3, do you recognize the name Tom Abrams?
A. Not at this time.
Q. And it indicates here, the bottom of that paragraph, "He also would like to see nationwide market research from healthcare practitioners to determine what the message is the doctors are getting from our promotional efforts."

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Do you see where that is?
A. Hang on a second. What paragraph is that.
Q. It's the second full paragraph that starts "Tom Abrams interjected," and it's the last line of that paragraph.
A. Yes, I see it.
Q. Okay. Do you know if Purdue undertook bringing in a nationwide market research firm to conduct this research?
A. I don't know. I mean, I don't know either way.
Q. Okay. Now, you talked earlier about the surveillance that Purdue did, RADARS and efforts like that. Are you familiar with the Top 100 Counties initiative at Purdue?
A. No.
Q. And did you ever become aware of Maine as a hotspot, obviously not a county, but for opioid abuse and diversion?
MR. PETRILLO: Object to the form.
A. Okay. I became aware that upstate Maine had a significant abuse and division problem.
BY MS. SINGER:

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Q. Do you remember when you became aware of that?
A. I'm not sure.
Q. Okay. I'll give you all these. So this is Exhibit 19.
(Whereupon, Purdue-Wright-19 was marked for identification.)
BY MS. SINGER:
Q. So it doesn't have a Bates number, it's "Prescription Drugs. OxyContin Abuse and Diversion and Efforts to Address the Problem," dated December, 2003 by the GAO.
Do you recognize this document?
A. I read it -- I recognize that I read something like this at the time.
Q. Okay. And that would have been back somewhere around December, 2003?
A. 2003.
Q. Okay. And if you could turn to Page 10 of the report, please.
A. Okay.
Q. Do you see in the first full paragraph on the report "After learning about the initial reports"?
A. I see that paragraph.

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Q. Do you mind reading that out loud, please?
A. "After learning about the initial reports of abuse and diversion of OxyContin in Maine in 2000, Purdue formed a response team made up of its top executives and physicians to initiate meetings with federal and state officials in Maine to gain an understanding of the scope of the problem and to devise strategies for preventing abuse and diversion."
Q. You can read one more sentence, please.
A. "After these meetings, Purdue distributed brochures to healthcare professionals that described several steps that could be taken to prevent prescription drug abuse and diversion."
Q. And were you familiar with that effort at Purdue Pharma?
A. I don't know if I was familiar at the time. I don't remember it.
Q. Okay. Do you recall if you were involved in any effort like that?
A. I could have been. I don't -- I honestly don't remember.

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Q. Okay.
(Whereupon, Purdue-Wright-20 was marked for identification.)
BY MS. SINGER:
Q. Exhibit 20 is PKY180277573, and it's a PowerPoint titled "Protecting Patients' Rights to Proper Pain Management - New England Initiative."
Have you seen this document before, this presentation?
A. I don't think so.
Q. Okay. And do you know who Robin Hogen is?
A. I don't know his exact title, but I knew where his office was in the building.
Q. Okay. And this is -- he's someone you interacted with or worked with at Purdue?
A. On a limited number of times.
Q. Okay. And do you know if he was a doctor or a scientist?
A. He was a -- I don't know what his professional background was. He was a senior executive in the company, and that's about as much as I knew.
Q. Okay. So if you could turn to Bates

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number 579. Do you see the first slide, "Preparation: Maine Strike Force"?
A. Mm-hmm.
Q. And under the third indented bullet of internal personnel, do you see your name?
A. Yes, I do.
Q. Okay. And does that refresh your recollection about anything you might have done in connection with the Maine Strike Force?
A. No, because I don't think I did anything. I mean, I can't identify anything with respect to the Maine Strike Force.
Q. Okay. And I just want to turn you back to the first page. I'm sorry, let's start actually on the second page which is Bates number 574. Under "Today's Situation" it describes "Increased media exposure of diversion and abuse of OxyContin in Maine." That's something you recall, correct?
A. Yes.
Q. And "Numerous physician inquiries about Purdue's plans to address abuse issue." Was that something that you remember being involved in or hearing about at Purdue?
A. That would have gone someplace other

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than me. That wouldn't have gone to my group.
Q. Okay. Do you remember hearing about it?
A. We knew about the -- I knew about the cases in Maine, and I knew about Maine's concern about the cases. I don't know -- I don't know how many physician inquiries we got or what the physicians were saying.
Q. Okay. And what about the last bullet, "Evidence of patient concern and reticence to use drug," were you aware of that?
A. I have no idea about that.
Q. Okay. All right. And moving to the second slide on this page under the heading "How Did We Get Here?", did you hear that the US attorneys sent a letter to healthcare providers in Maine warning of OxyContin abuse?
A. I don't know about that.
Q. Okay. And then just turning back to the first slide, actually the second slide on the first page, 573, do you see the slide "Goal and Objective"?
A. (Nodding in the affirmative).
Q. And can you read aloud what's listed there as goals -- as a goal and objective for

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Purdue Pharma?
MR. SNAPP: Object to the form.
A. "Goals and Objectives.
"Sustain and increase OxyContin prescriptions.
"Increase proactive treatment of pain.
"Position OxyContin as safe and effective therapy."
And "Diffuse concerns about OxyContin/opioids stemming from high profile news coverage of abuse."
Q. And do you remember discussions about efforts to accomplish those goals and objectives?
MR. SNAPP: Object to the form.
A. Those weren't the discussions we were having.
BY MS. SINGER:
Q. Okay.
A. I mean, not in my group.
Q. Okay. And you don't recall discussions with Robin Hogen's group about that?
A. No, no, no, not at all.
Q. You're getting a reprieve from one document.

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Okay. This document we're about to mark was produced natively under the Bates number PPLPC013000068011. It's Exhibit 21.
(Whereupon, Purdue-Wright-21 was marked for identification.)
MS. SINGER: Can I take one of those back? I'm sorry.
BY MS. SINGER:
Q. And if you can turn to the first colored page. By all means, take your time to look through it.
(Witness reviewing document.)
Q. Tell me whenever you're ready to talk about it.
(Witness reviewing document.)
Q. So do you remember this PowerPoint, Dr. Wright?
A. I think I recognize it as one of a series of PowerPoints that were developed through the Opioid X program.
Q. Okay. And this is a PowerPoint that you prepared, yes?
A. I do not remember preparing it, but it's likely to have -- the first draft is likely to have been mine.

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Q. Okay. I wanted to turn your to slide eight. It's not numbered, but it is the slide that's titled "Abuse and Addiction." And in this slide there's a distinction between addiction liability and abuse liability. Addiction liability is "The risk that an individual patient, using the drug as directed, will develop symptoms of addiction to the drug."
Is that an accurate statement or an accurate description of addiction liability?
A. Actually addiction liability, looking at it today, is not a recognized term of art in this area.
Q. Was it a term of art then?
A. It's what I wrote then, I think. What I was trying to do in today's terms would be to differentiate between misuse, abuse and diversion, and iatrogenic addiction.
Q. Okay. So what would you change, if anything, about the description of addiction?
MR. SNAPP: Object to the form.
A. I would probably add "properly managed individual patient."
BY MS. SINGER:
Q. Okay. So the risk that properly

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managed individual patients using the drug as directed?
A. Will develop addiction to the drug.
Q. Okay. And let's turn to the abuse liability. "The risk that individuals other than legitimate patients will misuse, abuse, and divert the drug." Does that reflect your views on what abuse liability of a drug is?
A. Well, that's the risk of misuse, abuse, and diversion. In this slide I was trying to separate two conflated ideas, that there were two domains in which you worried about abuse of a drug, iatrogenic addiction, misuse, abuse and diversion.
Q. And opioids create risks in both domains, correct?
MR. SNAPP: Object to the form.
A. Opioids create risks in both domains, both in iatrogenic addiction and misuse, abuse and diversion.
BY MS. SINGER:
Q. Okay. Can you define for the record iatrogenic addiction, please?
A. It changes from decade to decade, but to me right now iatrogenic addiction is the risk

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that a properly managed -- properly selected and managed patient who has an appropriate condition who receives treatment with the drug becomes addicted to the drug.

Q. And you have defined different domains, but an individual who becomes addicted to an opioid can also abuse an opioid, correct?

MR. SNAPP: Object to the form.

A. Everybody who has become addicted is abusing an opioid. Everybody who is abusing an opioid is not necessarily addicted. People can engage in misuse and diversion who aren't abusers or addicted, they're selling them. And what everybody struggles with is that these terms are all conflated and mean different things to different people.

It looks like in this presentation I was trying to say there's two things you have to worry about and both are important, one is the iatrogenic addiction and the other is misuse, abuse and diversion.

BY MS. SINGER:

Q. Okay. So let's turn to slide 13, which is titled "The Goal." Do you recall what you're talking about in this slide, what the

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goal is?

A. I do not remember independently. Reading this slide, I can conjecture.

Q. And what is your conjecture?

MR. SNAPP: Object to the form.

A. Back in 1990, 1995, 1985, back in that period, abuse of a pharmaceutical was considered to be a criminal justice problem. It was a problem for the cops. That, by definition, if a product was being abused, misused or diverted it was not being used as directed, and that did not affect the perceived safety profile of the drug.

By this point in time, and certainly going forward, what happens to the rest of society is viewed as an important part of the safety profile of the drug, that you can't view it as a criminal justice problem. That's where I was going with this.

BY MS. SINGER:

Q. Okay. In the third bullet, "Companies that make an advantage of the new situation will find a new market opportunity and thereby win," what are you referring to there?

A. If you recognize that it is important to consider the safety of the rest of the

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population other than the individual patient with the individual condition, if you integrate pharmacoepidemiology into your thinking, you'll be more successful.

(Whereupon, Purdue-Wright-22 was marked for identification.)

BY MS. SINGER:

Q. All right. Exhibit 22 is PDD8901212709 titled "Overall Medical Strategy for Purdue Opioid Products (Abuse and Diversion Resistance)."

Do you recognize this document?

A. I recognize it. I don't remember where I gave it, but I think it's -- I think it's a -- help me -- presentation I gave.

Q. Okay. And does the date March 1st through 2nd, 2005 seem about right? No reason -- or no reason to believe it's not right?

A. I don't know whether it's right or not, but it's what's written on the page.

Q. Okay. If you can turn to 2723. The Bates numbers are in the bottom corner.

MR. SNAPP: Can you give him a moment to look through the entire document, please?

MS. SINGER: If he asks, I'm happy --

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MR. SNAPP: If he needs --

MS. SINGER: Excuse me?

MR. SNAPP: If he wants time to look through the entire document, may he take --

BY MS. SINGER:

Q. So, Dr. Wright, let me just say so we don't have to have these interactions, if you ever need more time for a document, just ask, and you're welcome to take whatever time you need.

MR. SNAPP: Thank you.

A. I'm just familiarizing myself with what I said in this particular presentation. I gave dozens.

BY MS. SINGER:

Q. Sure. Of course.

(Witness reviewing document.)

A. Okay.

Q. Okay. And if you can turn now to Bates number 723, which is titled "The Abuse Problem."

A. I'm having problems finding Bates number 723.

Q. If you turn it sideways, that might help orient it like it's not a PowerPoint. And

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it's going to be in the back third.
A. Yes.
Q. Got it?
Okay. First of all, before getting to the particulars, I know you mentioned DAWN before, but can you describe what DAWN ED mentions are?
A. The federal government and in conjunction with a number of medical institutions runs a continuing and ongoing survey where nurses are sent in to go through emergency room records and abstract mentions involving drug abuse, those are ED mentions. They are not representing individual cases because a person could have two drugs in their mention because they were abusing two drugs. Those are then statistically compiled and made available to the rest of the scientific community.
Q. Okay. And what do DAWN ED mentions serve to indicate to you?
A. They're a surrogate of abuse of a drug in the community.
Q. Okay. And I'm never going to say it, on the bottom axis, equianalgesic doses?

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A. Yes.
Q. Did I say that right?
A. Equianalgesic doses.
Q. What does that represent?
A. People confuse potency and strength. Potency is how strong it is; strength is how much there is of it. When you prescribe a drug there could be huge differences in the potency of the drug and, thus, in the dose that's used. So a dose of fentanyl could be 300 micrograms or -- yeah, micrograms, a dose of morphine might be 5 milligrams, a dose of Codeine could be 60 milligrams. When you want to compare the two you can't just say, well, here's a milligram of fentanyl, because that's a huge amount of fentanyl. So you have to take and make the equianalgesic doses, the doses adjusted to morphine equivalence, so that you're looking at apples and apples instead of apples and oranges.
Q. Okay. Next to this chart, can you read what's written there?
A. "Abuse appears proportionate to the potency and amount of the opioid prescribed."
Q. Is that your view as of 2005?
MR. SNAPP: Object to the form.

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A. It reflects my views -- in 2005 I would have agreed with the statement because I wrote it that "abuse appears proportional to the potency and amount of the opioid prescribed."
Q. And do you still agree with that statement?
A. I still agree with that statement.
Q. Okay. And the relationship between -- never mind. Withdrawn.
A. May I also make sure that you correctly interpret that graph that you looked at?
Q. Sure.
A. It doesn't matter what the opioid is. It didn't matter which one it was. They all fell on the same line.
Q. Meaning the more drug, the greater the potency, the more abuse?
A. All of the Schedule II strong opioids, all of the strong opioids have about the -- have the same relationship at about the same magnitude.
Q. I know you said you gave lots of presentations. I don't think we'll take you through all of them, but this is Exhibit 23.

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(Whereupon, Purdue-Wright-23 was marked for identification.)
BY MS. SINGER:
Q. It's also produced natively, PPLPC013000094578. It's titled "Tamper-Resistance (What it is, What it isn't, What we need)."
When you've had a chance to go through it, can you tell me if you recognize this presentation?
A. I recognize it as one of the Opioid X presentations. I don't remember -- once again, I don't remember which one of them it was.
Q. Okay. So you don't remember who the audience was for this?
A. Not -- I don't remember what the audience was. But this is long enough and formal enough so that it was likely presenting outside of the group itself to someone else in the company.
Q. All right. Let's turn to slide four. So again, these aren't numbered because it's native, but it is the slide that has "NHS Drug Abuse."
And does that slide show the same

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relationship that we were just talking about?
MR. SNAPP: Object to the form.
A. No.
BY MS. SINGER:
Q. Is it different?
MR. SNAPP: Object to the form.
A. This slide is a slide of year by year. It's a government slide, I didn't -- we didn't produce this data, and the government had finally decided on new non-medical use as their term. It meant that it was non-medical use and it was new. They didn't use abuse or addiction or diversion, they used new non-medical use as their standard. And this was, I think, the National Center for Health Statistics, but I'm not -- might be National Health Service, I'm not sure what the acronym is at this point, it's been too long.
But what this shows is the number of cases that NHS calculated from their statistics for per year from 1965 to 2000.
BY MS. SINGER:
Q. Okay. And it shows that the trajectory increases over time, and particularly steeply after the mid 1990s, correct?

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MR. SNAPP: Object to the form.
A. That is correct.
BY MS. SINGER:
Q. So turning to "Risk Assessment," you indicate there that "The increase in opioid usage...is a major advance in pain management, but has occurred in a period with a significant increase in prescription opioid abuse." And you acknowledge this is a very big problem. I take it that's still your view?
A. This slide --
MR. SNAPP: Object to the form.
A. -- says it's a problem, it's a very big problem. I agree with that.
BY MS. SINGER:
Q. Too much paper. Forgive me.
All right. If you turn to the slide that is titled "Addicts." If you can look at the last bullet, or the last two bullets, "Taking drug to feel normal is part of addiction."
Is that an accurate statement?
MR. SNAPP: Object to the form.
A. The statement "taking drug to feel normal is part of addiction" is colloquial. I

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don't think it's a medical phrase. But I think it accurately reflects what someone who is active alcohol or drug-dependent feels. By the time their addiction has become severe, they're not taking the drug to get high or get euphoric or feel pleasure, they're taking the drug to feel normal, they're taking the drug to function. They're hurting.
BY MS. SINGER:
Q. And it's true they're -- well, you said it.
And then the last bullet there, "Accidental and intentional ODs are expected."
A. Yes.
Q. You also agree with that statement still?
A. Yes.
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. So let's turn to the slide that's titled "Where is the problem?" Why don't you read this one, please, if you will.
A. "Where is the problem?
"There are 1 to 2 million opioid addicts in the US.

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"There are 7 to 9 million opioid abusers.
"There are 10 million or more experimenters.
"Addicts prefer 'optimized' opioids.
"Addicts can get opioid as methadone." And there are now others.
"Most drug abuse casualties are among the abusers who surprise 70 to 80 percent of the purchasers.
"Most of the diverted drug goes to the addicts, who are the frequent, high volume users."
Q. Again, does this reflect your views as of the time you wrote this PowerPoint?
A. Yes.
Q. And now?
MR. SNAPP: Object to the form.
A. I'm not sure that -- I've been out of it too long. I don't know if the numbers are still right.
BY MS. SINGER:
Q. Okay. For the drug abuse casualties here in the statistics about abusers, again I know you talked earlier about two domains, but

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is it fair to say that people who begin as addicts are also abusers, people -- I'm sorry, began as patients can become addicts and abusers?

MR. SNAPP: Object to the form.

A. People who become -- people who are patients can become abusers. People who are patients can become addicts. People who are not patients can become abusers. People who are not patients can become addicts. And there's a wide variation in vulnerability, and this is a problem that affects the entire population.

BY MS. SINGER:

Q. All right. If you can turn to the last slide titled "Life-Cycle Management." So the first intended line, "If targeted for large FP/GP markets." Can you explain what that is?

A. If a drug is going to be used in a large patient population it needs to have a reduced risk, abuse risk profile.

Q. And what does FP stand for?

A. Family practitioner/general practitioner.

Q. Got it.

And the various bullets here, if

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targeting large family practitioners or general practitioner, large outpatient sales, emerging abuse trends continue upward, all of these listed here are reasons for moving to reduced abuse risk drugs, correct?

A. That is correct, ma'am.

Q. Okay. And some of these relate -- withdrawn.

So one of -- your last bullet here talks about avoiding restrictions on marketing. Explain what you mean by that.

A. If the FDA is doing its job and a product has too high an abuse risk for the population that it's going into, the FDA will have to step in and restrict marketing.

Q. And what about for competitive advantage and differentiation, what do you mean there?

A. If I was a practitioner and I had a choice between a product that I credibly believed was tamper-resistant or had a reduced abuse potential, and one that didn't, I'd pick the one that did.

Q. Okay. And all of these still strike you as the reasons, yes, among the reasons for

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reduced abuse profile?

MR. SNAPP: Object to the form.

MR. PETRILLO: Object.

A. The whole presentation was part of the Opioid X portfolio which was a huge program that Purdue mounted to try to find out how you would make a less abusable, less divertable product. It was not as simple as I thought. And this proposal looks like it was presented to an audience that I was trying to make it very clear to them that you need to do this, you need to do this for a new product, the world has changed.

BY MS. SINGER:

Q. Okay.

MR. PETRILLO: Is now a good time for a short break before you go to the next document?

MS. SINGER: Yes, that's fine. And I'm in the -- let's go off the record.

THE VIDEOGRAPHER: We are now going off the record, and the time is 2:42 p.m.

(Whereupon, a recess was taken.)

THE VIDEOGRAPHER: We are now going back on the record, and the time is 2:55 p.m.

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(Whereupon, Purdue-Wright-24 was marked for identification.)

MS. SINGER: All right. Exhibit 24 is PKY180816855, another Sponsor Meeting Minutes.

BY MS. SINGER:

Q. And, Dr. Wright, please take your time and take a look, let me know if you recognize this document.

(Witness reviewing document.)

Q. So, Dr. Wright, do you recognize this document?

A. Yes, I do.

Q. And what do you recognize it to be?

A. I recognize it to be more minutes from the sponsor of a meeting between the FDA and the company.

Q. Okay. And the meeting took place May 14th, 1997, does that seem accurate?

A. That seems accurate.

Q. And you were the chair of this meeting, correct?

A. I think it means I was senior at the meeting, but yes.

Q. And you were at the FDA at this point, correct?

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A. I believe so.
Q. Okay. And do you recall what this meeting related to?
A. I don't actually remember this meeting being -- this meeting as I remember the meeting, but the minutes are quite clear.
Q. Okay.
A. This would be the HXA, or the HX -- was it HXA or HX?
(Witness reviewing document.)
Q. I don't think you need to refer to it by the product name.
A. Okay.
Q. But is it correct to say --
A. This was a hydrocodone/naloxone combination.
Q. Okay. And it's a meeting not just between Purdue and the FDA, right?
A. It included Frank Sapienza and Gretchen, who I think I remember, but Frank for sure from the DEA.
Q. And also someone from NIDA, which stands for?
A. National Institutes on Drug Abuse.
Q. Okay. And according to the minutes,

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and to the best of your recollection, Purdue had asked for this meeting to discuss this reduced abuse liability hydrocodone product, correct?
A. Yes.
Q. And did Purdue have a request for how this drug should be scheduled?
MR. SNAPP: Object to the form.
A. What it says in the minutes is that the sponsor believes that the drug product should be Schedule IV.
BY MS. SINGER:
Q. And what is a Schedule IV drug?
A. Okay. A Schedule IV drug has the second from the bottom abuse liability and potential of the drugs in the schedule. My memory, which may be correct, was that at this time the hydrocodone, APAP/hydrocodone, aspirin, hydrocodone/NSAID combinations were in Schedule IV. Hydrocodone itself was in either III or II.
Q. Okay. Then if you look down the page under the "FDA Recommendations," do you see the second bullet point where you're noted as indicating that I think it's meant to be "addition of naloxone to an oral product may reduce the likelihood of parenteral abuse."

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What's parenteral abuse?
A. Parenteral is medical for injecting.
Q. Okay. For this -- but "for this product there is a greater potential for oral abuse than parenteral abuse."
A. That's what it says.
Q. And is that accurate?
A. I believe so.
Q. Okay. And you also indicate I think the fourth bullet point from the bottom that "The sponsor should demonstrate that the drug combination will not cause abuse or dependence."
Do you see that?
A. I don't know if that was my recommendation, but that was the FDA's recommendation.
Q. Okay. And that "The sponsor needs to demonstrate net benefit of the combination product to the public"?
A. Yes.
Q. And that "The sponsor shall demonstrate in Clinical and Preclinical studies that the addition of Naloxone in this drug product will deter abuse in both opioid naive patients and opioid dependent patients"?

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MR. SNAPP: Object to the form. It says addition, and I think you said addiction. I'm sure you want a clear record. You said addiction.
MS. SINGER: I said addition.
A. Allow me to reread it.
MR. SNAPP: I want to make sure the record is clear.
A. These terms get confused.
BY MS. SINGER:
Q. Particularly with typos.
A. "The sponsor should demonstrate in both clinical and preclinical studies that the addition of naloxone in this drug product will deter abuse in both opioid naive patients and opioid dependent patients." That's what the minutes say.
Q. Okay. And those seem to be accurate reflections of what was conveyed to Purdue at that meeting, correct?
MR. SNAPP: Object to the form.
A. They seem eminently sensible.
BY MS. SINGER:
Q. And then if you turn to Bates number 857, the fourth bullet point notes "Dr. Wright

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noted that hydrocodone abuse is primarily oral."
Again, does that reflect your understanding of hydrocodone abuse?
A. The hydrocodone products on the market at that time were not injectable. They could -- they contained large amounts of Tylenol or another aspirin or another NSAID, and so abuse of those products was mostly oral, immediate-release oral.
Q. So at the end of that bullet point it reports here that "As the data suggest the abuse is almost exclusively oral, what we would need to see with this product is that the oral abuse liability, particularly in the opioid abuser, is reduced."
Does that seem sensible to you?
A. That seems sensible.
Q. And then the last bullet point, "Dr. Wright recommended that the sponsor work with DEA and DDMAC in the advertising of the 'less abuse potential' than competitor's products."
Do you see that point?
A. I see that point.
Q. Does that also seem sensible to you?

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MR. SNAPP: Object to the form.
A. There would be great reluctance to market anything in this area with hydrocodone, and I felt that DEA would have strong feelings and DDMAC would have strong feelings against making such claims.
BY MS. SINGER:
Q. And why is that?
A. Hydrocodone at the time was -- and for most of the drug abuse epidemic has been more abused than oxycodone or OxyContin. It is prescribed in huge volume, it's used in acute pain and post-surgical, and it is also subject to -- I don't know, there isn't a term for this, but gray drug smuggling, the shipment of tablets that look like pharmaceutically manufactured tablets in the US from abroad. You know, I do not -- I'm not enough of a law enforcement person to know who is smuggling them in or the actual volume, but I know that it was large enough to distort the national statistics for hydrocodone abuse. Hydrocodone is a bad drug of abuse.
Q. Okay. And so in that bullet point you seem to be indicating that it's the advertising

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of less abuse potential that seems to have taught your attention, is that -- or that's the focus of your comment, is that correct?
MR. SNAPP: Object to the form.
A. I think the point I'm trying to make is do not hold false expectation of being able to make less abusable claims because DEA and DDMAC will have strong feelings on the subject.
BY MS. SINGER:
Q. Okay. And isn't there some risk that in advertising the product as having less abuse potential that you will prompt even greater prescribing, that doctors will lose caution about the product?
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Is that fair?
MR. SNAPP: Object to the form.
A. It depends on what you're doing. Because if you're prescribing in context, and you say this is a Schedule II narcotic that has high abuse potential, any claims you make about lowered abuse potential will be ignored. But if you have a big banner that says less abuse potential, and that's all you say, that's bad.

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(Whereupon, Purdue-Wright-25 was marked for identification.)
BY MS. SINGER:
Q. All right. Exhibit 25. Exhibit 25 is PDD8801176637, and it's an e-mail or memo from David Haddox to Robert Reder. When you have had a chance to look at it, please just let me know.
(Witness reviewing document.)
A. I've looked at it, ma'am.
Q. Okay. So do you recall this communication?
A. No, ma'am.
Q. Okay. And are you familiar with the program it discusses, MAD SS, or the MAD surveillance system?
A. Misuse, abuse, and diversion.
Q. Okay. Is that how they --
A. That was an acronym that we tried at one point.
Q. Okay. And were you involved with the MAD surveillance system?
A. Secondarily. That was predominantly Sid Schnoll and David Haddox.
Q. And who was Sid Schnoll?
A. Sid Schnoll is one of my mentors. He

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was a senior researcher in drug abuse. He's a member of the College of Problems of Drug Dependence, has had experience with previous abuse epidemics, and was hired by Purdue.
Q. So this communication describes a study that Purdue seems to be set to undertake, is that correct?
A. Well, it describes a study that has been proposed, one of --
Q. Go ahead --
A. Describes a study that had been proposed.
Q. Do you know if Purdue ever undertook that study?
A. I don't know whether they did it or not.
Q. And I notice that -- and it's a study of -- potential study of addiction abuse, correct?
A. It is a potential study of abuse, substance abuse disorders involving OxyContin, abuse of OxyContin.
Q. And one of the people CC'd on this e-mail is HRU right after Dr. Kaiko, and PDG. Do you know who HRU is?

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A. No. It would have to be a guess.
Q. Do you think it might be Howard Udell?
A. It might be Howard Udell. HRU, Howard, I don't know what Howard's middle initial is.
Q. Okay. And do you recall whether the legal department or the general counsel was involved in this potential study?
MR. SNAPP: Object to the form.
A. I was not involved in the planning of the study, so I don't know.
(Whereupon, Purdue-Wright-26 was marked for identification.)
BY MS. SINGER:
Q. Okay. All right. Exhibit 26 is PPLPC013000103821, and it's titled "Final Report - Top 200 Project. January 2004."
(Witness reviewing document.)
Q. So something about the document made you smile.
A. It meant that some work that we did actually got pushed up to -- and taken notice of.
Q. Okay. So do you recall the Top 200 Project?

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A. Not by that name.
Q. Okay. And do you know -- you were listed, if you can see under "Contacts," "Curtis Wright (CRAC)."
A. Mm-hmm.
Q. What does CRAC stand for?
A. I've forgotten what that particular acronym, it disappeared about -- it disappeared.
Q. And so I take it you don't know who led this project?
A. No. I don't know who -- I know about the part I had in it, but I now found out that I had a part in it because the project that we did is reported here.
Q. Okay.
A. But I don't know about the project as a whole.
Q. Okay. So we'll get to your part, I promise.
So it says here in the "Background" section, "In the period 1999 through 2000 the news media alleged several physicians had been involved in large scale diversion of OxyContin to the illicit market. This led to suggestions that Purdue 'should have known' that these

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physicians were engaged in these practices through routine examination of sales and marketing data."
Have I read that correctly?
A. You've read that correctly.
Q. And do you recall a conversation within Purdue about this issue?
A. Not quite -- well, not stated quite that way. But Purdue certainly -- the people that talked to me were not -- certainly did not want to be involved in promoting, marketing, selling, distributing, or otherwise having anything to do with physicians that were misprescribing or illicitly prescribing. And so I'm learning some bits by reading this, but this program looks like an attempt to say could Purdue have known, should Purdue have known, what could Purdue have known from the sales and marketing data.
Q. And so if you look down to the -- two-thirds down the page still at Bates number 821, it indicates that "Sales representatives calling on physicians in the top sales cohort were interviewed by experienced legal staff for indicators of illicit diversion."

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Were you aware that that was happening?
A. I knew that there was some kind of interviewing going on, but I didn't know who was doing it.
Q. Okay. And do you know why it was done by legal staff?
A. No.
Q. And did you see any of the results of those interviews from them?
A. No.
Q. And were you involved in any way in that process?
A. It's extremely hard to answer that because I can't tell if some question that I got bombing in by e-mail from someone was related to this or not. I answered a lot of questions about what could be looked for in talking to -- and looking at a clinic or making a sales call or doing a -- talking to a pharmacy or -- I would get questions and I wouldn't know why I was being asked.
Q. Okay. And I think we may have talked about this before, but do you remember who those questions came from?

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A. I'm tempted to say everybody. I got questions from a number of different sources. After I checked that they were Purdue employees and had a right to ask, I answered the question.
Q. Okay. If you turn to Bates number 823, you'll see in bolded text categories of "Impaired Physicians" and "Felonious Physicians."
Did you hear those terms used within Purdue?
A. I think I might have been responsible for them.
Q. That includes the third category at Bates number 824, "Diverting Physicians"?
A. I think that might have been language that I came up with in response to a question. I'm not sure.
Q. Okay. And so Purdue was aware that there were doctors who fit, to use your prior phrase, in each of these domains?
MR. SNAPP: Object to the form.
A. I don't know what Purdue was aware of. I made up -- if these are mine and they look -- they have the ring of my speech, but it could have been David, it could have been Sid, I don't

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know.
BY MS. SINGER:
Q. Okay. But they --
A. They have the ring, and the definitions sound like something I might have kicked in.
Q. Okay. But they did make it into this document on the Top 200 Project?
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Is that correct?
A. Well, it got into this document.
Q. Okay. And do you know what sources of information Purdue relied on in either coming up with these categories or identifying doctors who might belong in either of them?
MR. SNAPP: Object to the form.
A. I can only talk about my part, the analysis that we did --
BY MS. SINGER:
Q. Okay.
A. -- as part -- that I think are part of this.
Q. Okay. Please go ahead.
A. And what -- there were several

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sources. Dr. Haddox's program, Sid's program, the RADARS program had found some very startling information because they had concurrent abuse and diversion data by ZIP code for areas that it turned out that there had been a diverting pharmacy or physician, and by statistical analysis you could see that one or two of some of these diverting pharmacies or physicians had an enormous impact, they were capable of putting in a very large number of dosage forms into the illicit market and showed up as drug abuse cases. That was one source.
The other source was as part of our project we went and tried to find all of the cases around the country of people who were charged and convicted of diversion of pharmaceuticals, and then we did an analysis to find out what common factors we could find that might tell you that the person is one of these people.
Q. Do you recall who the "we" was that conducted that analysis?
A. Well, that analysis, that was my group. Nab Dasgupta was the lead investigator on -- was the lead person on that.

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Q. And do you remember what the time frame was for doing this inquiry? Yes, the dreaded date question.
A. It was in the new -- all I can tell you it was in the new building, so it would have had to have been after the move to the new building. It was after Nab came on board, and I don't know his start date. So it was somewhere in the 2003, 2004, or maybe 2000 -- I think -- I'm not sure. It would have been 2003, 2004.
Q. And do you remember as part of this process whether you identified specific prescribers who --
A. We did.
Q. Yes.
A. We did, yes, because they had been criminally charged and convicted, so we had their names.
Q. And did you identify any physicians who hadn't been criminally charged or investigated?
MR. SNAPP: Object to the form.
A. No. We used them as aggregate data.
BY MS. SINGER:
Q. Tell me what you mean by that.

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A. Okay. There are two ways that you can treat personal data, and one invades the privacy of the person and the other does not invade the privacy of the person, and there is ethics involved with that.
So for the physicians that we used as our test group, they were people that we had IMS data on but did not know their -- we pulled their names out of the files.
Q. Got it.
And did you use any external consultants in the project?
MR. SNAPP: Object to the form.
A. I don't know what the other parts of the project did. I just know what we did, and we didn't. Our part, we didn't.
BY MS. SINGER:
Q. Okay. And so under the category of Diverting Physicians at the top of Bates number 824, they're described as "providers engaged full-time in the illicit diversion of narcotics." Is that accurate? Was that a yes?
A. That is a yes. "These providers engaged full-time in the illicit diversion of narcotics."

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Q. Were those the prescribers who had been identified from the prescribers who had been charged or convicted?
MR. SNAPP: Object to the form.
A. Yes, they were.
BY MS. SINGER:
Q. And if you turn to Bates number 825, the second full paragraph, "These two factors," could you read that out loud?
A. "These two factors (excessive narcotics prescriptions filled for cash and failure to prescribe enough of the needed lower strengths) proved to be very specific predictors of aberrancy."
Q. Stop there, please.
Can you explain what that means?
MR. SNAPP: Object to the form.
A. For diversion, the highest strengths, the 160 when it was available, the 80 when it was not, were the target strengths, that's what you want to get, you want to get prescriptions for that because you are going to make the most money off of that. But most patients do not need 80 milligrams of OxyContin, they don't -- many of them don't need 40. I mean, I think the

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median dose prescribed was the 20.
And so if you are looking at a prescription profile for a clinic or for a pharmacy for that matter, and you see no 20s, you know, no 40s, a little bit of 40s, and then this huge blip of 80s, that's suspicious because that's not what the patients need.
Q. Okay. And then what about the excessive narcotics prescriptions filled for cash?
MR. SNAPP: Object to the form.
A. Most people today have some form of health insurance, either from the government, through Medicare or Medicaid, or from private health insurance. If people are showing up and are buying their prescriptions from cash, or in the case of dispensing physicians he's literally selling the drugs out of the medical office -- dispensing is legal in some states -- for cash, no credit cards, no checks, please, nothing but cash, that's suspicious.
BY MS. SINGER:
Q. Okay. And it says at Paragraph 4 at the bottom of the page, so having identified these factors for prescribers, Paragraph 4 says

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"We should examine pharmacy operations using a similar technique to see if there are any predictors that might identify pharmacies involved in the illicit trade."

And you're nodding your head.

A. I'm saying that is what -- you read that correctly.

Q. Okay. Do you know if Purdue undertook that work?

A. No, I don't know if it was done. But I don't know whether it was done or wasn't done.

Q. Okay. Did your group ever did that?

A. I don't know. Nab would have done it or the epidemiologist would have done it, and they might have done it without my necessarily knowing it.

Q. Okay. We'll come back to that.

Okay. A lot of ink went into this exhibit. So this is Exhibit Number --

MS. FORSTER: 27.

BY MS. SINGER:

Q. -- 27, and I don't think it had a native Bates number to it. So it is "Risk Identification, Risk Assessment and Management of Drug Formulation (A Regulated Company

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Perspective)."

(Whereupon, Purdue-Wright-27 was marked for identification.)

MR. SNAPP: I'm sorry, for the record, if it didn't have a Bates number, where did it come from.

MS. SINGER: It was produced by Purdue. I think it was just produced without a native cover to it with the Bates number, but we can search and clarify the record.

BY MS. SINGER:

Q. So, Dr. Wright, do you recognize this presentation?

(Witness reviewing document.)

A. Well, this is a draft of a presentation that I may have given to the College on Problems of Drug Dependence.

Q. And what is the College on Problems of Drug Dependence?

A. It's a group -- it's a members organization, scientific organization that has existed for some time that is individuals who are concerned with drug abuse, dependence, and medication safety.

Q. And you were a member of that?

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A. I believe I still am a member, but I have to check whether I paid this year's dues.

Q. My guess is they'll find you.

All right. If you can turn to the slide that is titled "Disaster." It is towards the front of the deck. Can you read the first bullet and the points underneath it, please?

A. "Unanticipated widespread abuse of a prescription medication is a disaster for:

"The patients.

"The prescribers.

"The public.

The company."

And "The Agents of Social Control. (DEA, FDA, NIDA, Police, Politicians, Prosecutions.....)"

Q. Do you agree with the statement here that "widespread abuse of a prescription medication is a disaster"?

MR. SNAPP: Object to the form.

A. I believe that I probably said this, and I believe it to be true. It is a very bad thing.

BY MS. SINGER:

Q. And when you talk about agents of

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social control, tell us how you mean that.

A. Well, I made it up because I didn't know how to fit -- or I think I made it up. I didn't know how to fit --

Q. I don't think they call themselves that.

A. I don't think they call themselves that, but I couldn't figure out how to make DEA and FDA and NIDA and police and politicians and prosecutors all fit together in one term, so it looks like I made up a term.

And they're people who are responsible for the smooth and orderly functioning of society. They are supposed to make things go well.

Q. Okay. All right. Let's turn to --

(Whereupon, Purdue-Wright-28 was marked for identification.)

BY MS. SINGER:

Q. We'll start Exhibit 28, it's another native production. So this did have a Bates number of PPLPC013000106089, and it's titled "Data Analysis Program, 1Q2004 Update" by Nabarun Dasgupta.

A. Yes, that's how you spell his name,

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Nabarun Dasgupta, we called him Nab. I think he he's finished his Ph.D by now. And he's a super, super smart little scientist.

Q. And you've now memorialized that, he'll be grateful.

So that is the Nab you've been talking about before?

A. Yes.

Q. Have you seen this presentation before?

A. I don't remember it specifically, but it looks like Nab's presentation.

Q. Okay. And does it reflect the work you were talking about earlier that you were doing in analyzing prescribers and types of prescribers who were engaged in diversion or inappropriate prescribing?

MR. SNAPP: Object to the form.

(Witness reviewing document.)

A. I think so.

BY MS. SINGER:

Q. Okay. I want to turn your attention to the slide "Screening by Recursive Partitioning."

A. Yes, ma'am.

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Q. And does this -- first of all, do you know what recursive partitioning is?

A. Yes.

Q. What is it?

A. It's a statistical technique available in most of the major high-end statistical programs. And what it enables you to do is you have some cases and you have some controls, people who have it, people who don't, people who are diverters, people who may or may not be diverters, and they're all mixed together. You can take a categorical variable and move across the values for that variable, in other words try different numbers that you plug in, and see how well it splits the main body of data. Okay. And then you can add another variable, and then you can add another variable, and then you can move the variables up or down in doing which one first and which one second. So it's a statistical technique where you sit there at the computer and you plug numbers in and you see how did that do, and you try that and how did that do, and try this and how did that do.

And your goal is to develop a set of indicators that takes a population that's this

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big and sifts out all of the cases that you're interested in into a little tiny bucket over here.

Q. Okay.

A. And some statistician will not think I described it very well.

Q. So this is the technique that Dr. Dasgupta used to identify the factors that were predictive of diversion or variant prescribing, correct?

MR. SNAPP: Object to the form.

A. That's the technique.

BY MS. SINGER:

Q. And this is the technique that allowed you to identify that it was high dose and high cash prescribers who were of greatest concern?

MR. SNAPP: Object to the form.

A. Nab Dasgupta used a number of -- this was one analysis, he did a number of analysis, and he used a number of partitioning variables. Looking at his results here on the slide, he started out with 200,000 total and 142 identified aberrant prescribers, and not prescribing enough of the lower strengths, split them up a little bit, total net cash sales,

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split them up a little bit, percentage ever cash RX, split them up a little bit, and he ended up with what it says here, 100, Top 100 Project, I still don't know the name, that he describes. And what he describes are physicians in trouble.

BY MS. SINGER:

Q. Okay. And I want to turn also to "Risk Factors." So explain what risk factors are in this context.

A. Okay. In epidemiologic studies risk factors are things that say these are associated with the cases more than with the rest of the population. These are things that happen more in whatever you're looking at, tuberculosis, leprosy, drug -- aberrant drug prescribing, they're more likely to be, and they are more likely to have, and if you see these things then you need to be concerned that they may have the target behavior, disease, condition.

Does that help?

Q. It does. Thank you.

And then in addition to risk factors, Dr. Dasgupta reached conclusions --

A. Well, he found risk factors and he found protective factors.

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Q. That's right.
A. And then he reached his conclusions which are that bankruptcy, debt is a risk factor for suspected criminal prescribing. Large volume prescribing of opiates by a non-specialist is a risk factor. Pain specialization appears to be a protective factor. And simply screening what's currently available on the internet for everybody, you, me, everybody, has some efficacy.
Q. So let's go back to two of them. Internet screening, you mean just doing internet research on a doctor?
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. Is that right?
A. Okay. Nab purchased, and I do not remember the name of the service, but he purchased -- at that time there was an internet service that would tell you about someone, pull all their records, see if they were in legal proceedings, scan them for whatever could be found in the public domain, and Nab thought it would be useful, and that's what he meant by internet screening. So he would plug in this

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target doctor's name that we knew about, and say what do we get on him? And we got back that he'd been divorced, that he's declared bankruptcy twice, that he was in arrears on his taxes, and a whole bunch of stuff. And those were the factors that Nab said could you use that, could that work, would that help you.
Q. And his answer was yes, correct?
A. He thought so.
MR. SNAPP: Object to the form.
BY MS. SINGER:
Q. And then non-specialist status, just to make sure we understand that, a non-specialist, you're talking about a family practitioner or general practitioner, is that accurate?
MR. SNAPP: Object to the form.
A. Family practice is actually a specialty now. So it would be someone who didn't do a residency.
BY MS. SINGER:
Q. So, for instance, a primary care -- well, not necessarily.
A. General practitioner essentially. Can I bring something to your

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attention?
Q. I wouldn't dare stop you.
A. If you look at the last page of this element, I just want to bring up the fact that if you look at the states that were involved in the state medical board sanctions, Florida leads the state and leads the count. And it turns out that dispensing from your office is a risky practice in terms of diversion, abuse, and diversion of opioids.
Q. Meaning it's often predictive, it's in that category of factors?
A. It's in those categories of factors. I believe Florida has been concerned and has done something about that.
(Whereupon, Purdue-Wright-29 was marked for identification.)
BY MS. SINGER:
Q. So Exhibit 29 is an article, it doesn't have a Bates number, "Association between non-medical and prescriptive use of opioids." And the lead author is Dr. Dasgupta, correct?
A. Yes.
Q. And are you also listed as an author?

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A. This is pretty much my entire group.
Q. Okay. So everybody listed among the authors are Purdue Pharma employees who worked for you or with you?
A. Well, they didn't work for me. Salvatore Carino was the computer guy in marketing who had the IMS data that we used, and so he was the one that had to make the data available to us and make it available in a form that we could use.
Meredith Smith was the epidemiologist that was hired to service both Dr. Haddox and myself in that group. David Haddox, myself, Doug Kramer, medical officer, and Mary-Ann Zalman was the medical writer. I remembered who she is at last.
Q. All right. So you recognize this article as one you all participated in, correct?
A. Yes.
Q. If we turn to Page 141. And by the way, let's just put the date on the record. The date of the publication is 2006, correct?
A. (Nodding in the affirmative).
Q. So if we turn to Page 141. So if you look on the top paragraph of the first column,

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can you read the sentence beginning "The remarkable constancy"?
A. "The remarkable constancy of the relationship of drug abuse sequelae to the magnitude of prescriptive usage, among opioids, suggests that as legitimate use of an opioid medication increases, the prevalence of non-medical use and its consequences increase as well."
Q. Okay. And does that correctly reflect the conclusions you reached as a result of your study?
A. That is the primary conclusion of the study, along with the secondary finding that it didn't matter what the drug was.
Q. And so can you -- the sentence you read out loud, can you restate that in more lay terms, please?
MR. SNAPP: Object to the form.
A. Yes.
BY MS. SINGER:
Q. Could you do that?
A. Yes. We have a control system in this country that is intended to prevent drugs leaking out of the prescriptive proper use for a

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patient. Our -- my hypothesis going in, and it was my hypothesis, is that has a certain percentage effectiveness. Some percent of the drugs that are intended to get to patients leak out. When they leak out, if they leak out in a fixed amount, then the number of cases will be constant. There's so many drug addicts who are diverting them. If it's a percentage, you know, the system is 99.9 percent effective, say, then as you put more drugs into the prescriptive drug flow, as there are more in the marketplace, as there's more in the pharmacies, as they're more in the prescriptions, as there's more in the medicine cabinets at home, more will leak out.
So given the given set of controls that were operative during the period of this study, the more prescription drugs you had in the marketplace the more drug abuse cases you would have.
Q. And what was the period of the study?
A. You would ask that. 1994 to 2002.
Q. Okay. And so going back to how you presented this, it is not a fixed amount, it is a percentage, so you increase the volume you increase the --

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A. Number of cases.
Q. And in reaching this conclusion you relied again on DAWN ED data, correct?
A. The sources of this data were multiple. One was the DAWN emergency department data which was -- had some problems because they changed -- periodically they change those surveys and assure us that everything is okay. Sometimes statistically they're not. And we then had to use the IMS data for how many kilos of oxycodone, how many kilos of hydrocodone, how many kilos of fentanyl, how many kilos of morphine were in the pharmaceutical pipeline, so we had to reduce all of the companies that made morphine down to a total, and then we had to adjust so that we were adding the right amount of morphine and the right amount of oxycodone and the right amount of fentanyl, converting it all to morphine equivalence.
Clear so far?
Q. Crystal.
So effectively, DAWN ED data gave you the measure of abuse, correct?
A. It was a surrogate measure of abuse.
MR. SNAPP: Object to the form.

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BY MS. SINGER:
Q. And the IMS data gave you have the volume of supply, correct?
MR. SNAPP: Object to the form.
A. The IMS data gave us an approx -- a good approximation of the amount of each opioid in the supply chain.
BY MS. SINGER:
Q. And DAWN ED data, as you've noted, only picks up people who show up in hospitals, correct?
A. Emergency departments. And it's pretty good.
Q. Okay. Does it get at the number of people who may be addicted or abusing who don't end up overdosing?
MR. SNAPP: Object to the form.
A. Okay. DAWN ED data will not detect someone who has not had a medical encounter. However, the likelihood of a medical encounter for someone who is seriously abusing drugs is so high that sooner or later they'll end up in the emergency room.
BY MS. SINGER:
Q. Okay. One last question about IMS

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data. We're going to go back to the GAO report, which was --
MS. FORSTER: Exhibit 19.
BY MS. SINGER:
Q. -- Exhibit 19, please.
Do you recall when you began using IMS and DAWN data to identify abuse, diversion, and problem prescribing?
MR. SNAPP: Object to the form.
A. Okay. I only know when we began to analyze the data, and I don't know that very precisely, but it was in the new building and it was after Nab came, so I'm thinking likely to be 2004, 2005.
BY MS. SINGER:
Q. Okay. And Purdue had had IMS data prior to 2004, 2005, right?
A. I do not know for sure, but I'm sure they did.
Q. Okay. And if I can turn you to Page 40 of the GAO report. The bottom paragraph starts "Since the launch."
A. Mm-hmm.
Q. Do you mind just reading the paragraph on into the next page out loud, please?

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A. "Since the launch of OxyContin, Purdue has provided its sales force with considerable information to help target physicians and prioritize sales contacts within a sales territory. Sales representatives routinely receive daily, weekly, monthly, and quarterly physician prescribing reports based on IMS Health data that specify the physicians who have written prescriptions for OxyContin and other opioid analgesics, and the number of prescriptions written."
Q. Go ahead and read the next sentence.
A. "Although this information has always been available for use by Purdue and its sales representatives, it was not until fall 2002 that Purdue directed its sales representatives to begin using 11 indicators to identify possible abuse and diversion and to report the incidents to Purdue's General Counsel's Office for investigation."
Q. Okay. You can stop there. Thank you for reading that.
Were there any discussions that you can recall in Purdue, within Purdue, about using IMS data for compliance before you began your

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analysis?
MR. SNAPP: Object to the form.
A. I cannot be sure, but I think maybe I had a hand in answering a question that led to the 11 factors that they were looking for in that discussion, in what I just read, at least I hope so.
BY MS. SINGER:
Q. And do you recall, in the few years you were at Purdue before then, any energy within the company to turn those kinds of data sources to use for compliance and preventing diversion, and not just for sales?
MR. SNAPP: Object to the form.
A. Yes, I was one.
BY MS. SINGER:
Q. And beyond you?
MR. SNAPP: Object to the form.
A. I don't know, because the -- when I was working with the few contacts we had in sales on the programs that we've already went through and described, they were very concerned about how they might use this data, about what techniques are available, but there had been some egregious mistakes made that made them very

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concerned about using them properly.
On one occasion I heard a report secondhand, I can't verify that it's true, that the DEA came in black jacket and boots to a pharmacy because they were prescribing so many opioids, and it turns out that they were the pharmacy that filled for a major cancer center.
So the problem was not how to -- the problem was not the IMS data existed, it's how to use it and how to tell good from bad when you're using it.
BY MS. SINGER:
Q. And in terms of that conversation about how to use the data and the 11 factors and those things you've talked about, was there anything before Dr. Dasgupta's report that really gave a direction to that?
MR. SNAPP: Object to the form.
A. You asked me if there was anything before Dr. Dasgupta's report which came out in 2006 that gave direction to that, and Dr. Haddox and Dr. Schnoll were both very vocal in this area.
BY MS. SINGER:
Q. And what did their work produce?

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A. I don't know, because concerns about marketing, sales reps, and prescribing, and especially improper detailing or improper prescribing, would have been handled by the ethics group, and they did not tell the rest of us what they were finding.
Q. And who was the ethics group?
A. The chief ethical officer was Howard Udell. And if -- I mean, we all knew that if we had anything we were concerned about in the company at all ever to go directly to him.
Q. And Howard Udell ultimately ended up pleading guilty, correct, in the 2007 --
MR. SNAPP: Object to the form.
A. I don't know the details of any of that. That happened after I left the company.
MS. SINGER: Okay. Let's leave it.
If I can just take five minutes and check my notes, and then we'll be done and pass the baton.
THE VIDEOGRAPHER: We are now going off the record, and the time is 3:58 p.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 4:08 p.m.

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BY MS. SINGER:
Q. All right. Dr. Wright, we had talked about the integrated safety study earlier, and it took us a minute to find a copy of it, but Exhibit 31 is PDD7024302094.
(Whereupon, Purdue-Wright-31 was marked for identification.)
BY MS. SINGER:
Q. Is that right? No, I read the wrong Bates number and gave you the right document. The correct Bates number is PDD1501090033.
When you've had a chance, whenever you've had a chance, let us know if you recognize that to be the integrated summary of safety for OxyContin.
MR. SNAPP: Do you have another copy?
MS. SINGER: I gave two.
(Witness reviewing document.)
MR. SNAPP: Looks like it's missing a Bates number.
MS. SINGER: Excuse me?
MR. SNAPP: My copy is missing Page 1 of the document.
MS. SINGER: So it's in the form --
MR. SNAPP: It skips from 33 to 35, 34

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is missing from my copy.
MS. SINGER: We can sub one in.
MR. SNAPP: I just want to make sure the witness is --
A. I'm missing the end of it.
BY MS. SINGER:
Q. What's your last Bates number?
MR. PETRILLO: I think the witness's copy is also missing 34. And the last Bates number is 41.
MS. SINGER: Okay. All right. We've had some copying issues.
A. In answer to your question, except for the fact that it's missing bits, this appears to be my integrated summary of safety.
BY MS. SINGER:
Q. Okay. So what we'll do is during the next break we will provide you all with complete copies.
In the interim I just want to direct Dr. Wright's attention to Bates number 40, fortunately one of the Bates numbers you have.
A. No.
Q. No?
A. I go from 37 to 39 to 41.

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Q. Okay. We will deal with that on the next questioning. My apologies for that.
Okay. We talked earlier this morning, a lifetime ago, about the duties of a responsible pharmaceutical company, and you talked about what you thought were the elements or hallmarks of that. And we talked about the role of the package insert.
Now, is it accurate to say that in your view the role of the package insert is to convey full and accurate information to the prescriber about how and when to use the product?
MR. SNAPP: Object to the form.
A. The intent of the package insert is to, from my perspective now, convey mutual information that is agreed to by both the company and the FDA about what is known about the drug both from a scientific perspective and in terms of what the experience has been with it, and the usage of the product in a proper fashion. It's not nearly enough to use any of these drugs. There's a whole bunch of other things that the practitioner must bring to the interaction with the patient. But it's an

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agreed to starting point for both the company and the prescriber.
BY MS. SINGER:
Q. You said it reflects the scientific knowledge and clinical experience at the time the package insert is drafted, correct?
A. That's correct, ma'am.
Q. And the scientific studies evolve over time? There's more scientific knowledge, correct?
A. That is correct, ma'am.
Q. And there's more clinical experience as the drug is used in the general population, correct?
MR. SNAPP: Object to the form.
A. I believe that is to be correct, too.
BY MS. SINGER:
Q. And is it fair to say that in your opinion and experience, a responsible company takes advantage of that scientific knowledge and clinical experience to make sure that the package insert continues to accurately reflect what is known about the drug?
MR. SNAPP: Object to the form.
A. That's difficult, and it's difficult

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because changing the package insert is a huge undertaking both for the company and for the FDA. Either the FDA can request changes in the package insert, or the company can request changes in the package insert through a process of amendment of the NDA.
Where my knowledge fails, because there have been changes since -- there were changes when I was at the FDA and there have been changes since I was at the FDA, and it was covered -- and it's the responsibility of DDMAC, when to make a change, why to make a change, what change to make all are things that drug advertising has strong -- has control over and has strong input into.
There's also the question of providing what are called reprints to the physician which are updates on science that has been done since the drug was approved, and there are complex rules that I do not -- I'm not up to today on on how you may do that, when you may do that, if they have to request it, if you can offer it, all of which are beyond my knowledge and skill.
BY MS. SINGER:
Q. So given all of that, it's certainly

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not, again, your experience and your impression that a package insert remains fixed in time?
A. Package inserts, to my knowledge, are changed as significant new knowledge accrues.
Q. And the purpose, again, of reflecting that new important or significant information in the package insert is to make sure that the prescription drug is used safely and effectively in the population, correct?
MR. SNAPP: Object to the form.
A. Purpose is a bit difficult, but it is in the public interest that a package insert that requires modification gets modified.
BY MS. SINGER:
Q. And again, so that prescribers have the important information, not necessarily all of the information, to make decisions about how to guide and use the product with their patients?
MR. SNAPP: Object to the form.
A. The purpose is to enable pharmacists, prescribers, and these days health insurers, sadly or to benefit, what the drug does, how to use it safely, and what is known about its toxicity and problems.

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MS. SINGER: Okay. All right. I have nothing further at this point.
THE VIDEOGRAPHER: Should we go off?
MR. STEWART: Take about five minutes.
THE VIDEOGRAPHER: We are now going off the record, and the time is 4:17 p.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 4:31 p.m.
EXAMINATION
BY MR. STEWART:
Q. I'm Mike Stewart, I represent a number of plaintiffs in the State of Tennessee, including a number of district attorneys general.
I'm going to state the terms of our agreement whereby we're having this discussion today with your counsel and give him the opportunity to respond.
But I'm planning to take just two hours of testimony, and I've agreed I don't plan to come back and take additional testimony from you in this case. If there is a situation where some particularly significant document has turned up that we have not received, then we may

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seek to depose you on that issue. However, we'll work with your counsel to minimize any inconvenience involved, whether by telephone or perhaps a very short follow-on deposition.

MR. STEWART: Does that make sense?

MR. SNAPP: That's agreed.

MR. PETRILLO: That does make sense. I just want to say as a practical matter, I take it that you agree that if the documents have been produced as of today that the document will not be a cause for additional deposition time.

MR. STEWART: That makes sense. The only thing I would say is there is actually a dispute in this case, which I think you're unaware of, about whether documents produced have been done in a form that works. But I think you can see that we're going to try to be reasonable. Yes, if we've had a good opportunity to review it, then that would be true.

MR. PETRILLO: Okay. That's fine. And we'll be reasonable, too.

And we're doing this in lieu of a formal notice of deposition which we did not receive from this particular party, so I would

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advise that we proceed.

THE WITNESS: I will proceed.

BY MR. STEWART:

Q. Thank you.

With that, sir, I'd ask you to turn to Exhibit 26, which I think is the second one in your pile, and you've already looked at it.

Do you remember reviewing Exhibit 26?

A. I remember looking at it.

Q. Can you turn to the very last page where I think you'll find a list of providers, I believe? Is that what the last page of Exhibit 26 has?

A. The last page of Exhibit 26 looks like a representative sample data.

Q. And what sort of sample data? Can you tell by the title and how it's incorporated into the document what that list is showing us?

A. There is an identifier, which I don't know what it means and would need those codes to know what it means. Narcotic treatments, OxyContin treatments, percent cash treatment, hydrocodone street value, methadone street value, fentanyl street value, morphine street value, oxycodone street value, OxyContin street

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value, and total street value.

Q. Is that a list, do you think, of prescribers? Can you tell? And you may want to look at the prior page to see if that's correct.

A. It looks like a list of the 44 aberrant prescribers.

Q. Did you -- I'll tell you our review of the -- or can you tell, on that list of aberrant prescribers, can you tell if there's an identifier that would show you which prescriber it is?

A. If you knew what the ME number meant and the IMS ID meant, then you could tell who the prescriber was.

Q. Looking at this today, if I told you that three of those prescribers are from the State of Tennessee, I take it you couldn't contradict or confirm it one way or the other?

MR. SNAPP: Object to the form.

A. I could not tell.

BY MR. STEWART:

Q. But you know there are numbers on that document that would allow us to correlate that document to particular prescribers?

MR. SNAPP: Object to the form.

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A. If you had the codes you could.

BY MR. STEWART:

Q. Turn now to another exhibit that you've already been handed, which is Exhibit 28. That's this PowerPoint presentation that you have already reviewed.

Do you recall that?

A. I remember it.

Q. Okay. Do you remember Exhibit 28 as a document entitled "Data Analysis Program," first Quarter 2004 Update?

A. Yes, I do.

Q. I'll tell you I put, just so we can move quickly, a green sticky on that document which should lead you to a page entitled "Screening by Recursive Partitioning."

Do you see that?

A. Yes, I do.

Q. Okay. And my question is, do you know if Purdue, after this analysis that's embodied in this PowerPoint was conducted, did it follow up to analyze those doctors that had 10 to 20-milligram OxyContins representing less than 35 percent of all OxyContin prescription sales?

MR. SNAPP: Object to the form.

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A. I don't know.
BY MR. STEWART:
Q. Do you know, looking at the second bullet, if Purdue ever followed up to analyze the doctors whose patients paid more than 100,000 in cash for narcotic analgesic prescriptions to determine whether those doctors were involved in diversion?
MR. SNAPP: Object to the form.
A. I don't know.
BY MR. STEWART:
Q. Do you know if Purdue ever followed up, looking at the third bullet, to analyze those doctors who had 17 percent of their prescriptions for all drugs paid for in cash to determine whether any of those doctors were involved in diversion?
MR. SNAPP: Object to the form.
A. I don't know.
BY MR. STEWART:
Q. Now I'd like you to turn to the page, and I tried to mark it, the page that shows risk factors. Do you see that? You have a page in this PowerPoint marked Exhibit 28 that's entitled "Risk Factors"?

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A. Yes, I see it, sir.
Q. And do you see it has financial, clinical, and personal risk factors?
A. Yes, I do.
Q. Looking at all these risk factors, do you know if Purdue, in following up on the analysis that's presented in this PowerPoint, ever looked at these risk factors and applied them to prescribers throughout the United States to identify prescribers that might be involved in diversion?
MR. SNAPP: Object to the form.
A. I don't know.
BY MR. STEWART:
Q. I'd like to hand you a document and ask you if it's got the exhibit sticker 32 on it.
(Whereupon, Purdue-Wright-32 was marked for identification.)
BY MR. STEWART:
Q. I've got copies for both counsel.
Do you see that document?
A. Yes, I do.
Q. It's got Exhibit 32, a sticker on it identifying it, fair?

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A. Yes, I do.
Q. Can you look at Exhibit 32 and tell me whether or not you recognize it as a document that you authored? And I'll point out the last page of the document ends with the word "Curt."
A. I do not remember the document, but I have no reason to believe I did not author it.
Q. Looking at the substance, do you see that the document contains a series of points under headings which are entitled "Costs associated with criminal diversion," "By patient diversion," and so forth? Do you see that?
A. Yes, I do.
Q. Are these lists consistent with your understanding of the costs associated with criminal diversion, by patient diversion abuse, and the other listed categories?
MR. SNAPP: Object to the form.
A. Opioid X health economics.
(Witness reviewing document.)
BY MR. STEWART:
Q. I guess I should put this on the screen.
A. Could you repeat the question?
Q. Sure.

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Do you see on the document, now I've put it on the screen, if you look at the page that has a Bates number, which is the number at the bottom right-hand corner, that ends with 2047, do you see that page?
A. Yes, I do.
Q. Now, do you see, for example, there's a paragraph on this document that says "Costs associated with criminal diversion," and it lists a series of costs.
Do you see that?
A. Yes, I do.
Q. Does that look like something you would have written to summarize the costs of criminal diversion?
MR. SNAPP: Object to the form.
A. I don't know if I'm the sole author, but I probably contributed to it.
BY MR. STEWART:
Q. That's consistent with your thinking?
A. It is consistent with my thinking.
Q. How about the list of "Costs associated with By-patient diversion," similarly consistent with your thinking?
MR. SNAPP: Object to the form.

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A. It is consistent with my thinking.
BY MR. STEWART:
Q. Do you see that the second paragraph of this statement says "Such costs cannot be determined in controlled studies (too low frequency) but can be identified by epidemiologic techniques and the fraction due to an individual drug estimated."
Do you see that?
A. I see that.
Q. Fair to say that's something you would agree with and have, in fact, said in other contexts?
MR. SNAPP: Object to the form.
A. In theory. I must confess that health economics is tricky, and I'm not sure I know how to do that. But the way in which you would approach this kind of thing would be by that way.
BY MR. STEWART:
Q. And I'd just like -- I'm going to get to it, do you see the list, it's got "Costs associated with abuse"?
A. Yes.
Q. Again similarly, is that consistent

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with your thinking, this list of costs associated with abuse --
MR. SNAPP: Object to the form.
BY MR. STEWART:
Q. -- on the page marked 207?
MR. SNAPP: Object to the form.
A. Those are representative costs. I'm not sure they're complete.
BY MR. STEWART:
Q. If we turn over to the page, Exhibit 32 that has a Bates stamp that ends in 2048. Do you see there's a statement "Costs associated with addiction"?
A. I do, sir.
Q. Again, do those costs that are listed here, are they consistent with your view of costs associated with addiction?
MR. SNAPP: Object to the form.
A. Yes, they are, sir.
BY MR. STEWART:
Q. And finally, do you see there's a "Costs associated with misuse/abuse/addiction," and you've got a final list, is that consistent with your understanding?
MR. SNAPP: Object to the form.

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A. With my guessing. I don't know what percentage of pharmacy boards, state boards, impaired professional programs are associated with abuse and diversion, but I wrote them down as possibles.
BY MR. STEWART:
Q. I'd like to hand you another exhibit which is marked Exhibit 33.
(Whereupon, Purdue-Wright-33 was marked for identification.)
BY MR. STEWART:
Q. Do you see you have Exhibit 33 in front of you?
A. I have Exhibit 33 in front of me.
Q. And can you turn to the first page and tell me whether you see it marked -- or the second page of the exhibit, can you tell me whether it's marked with a Bates number 0087?
A. It is so marked, sir.
Q. And do you see that this is a description of the RADARS system?
A. It's a description of the early concept of the RADARS system.
Q. Do you know if you wrote this description?

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A. I don't know if I solely authored it. I suspect that the -- from the typeset and the way it's laid out that it looks like a Curt Wright document.
Q. Thank you.
(Whereupon, Purdue-Wright-34 was marked for identification.)
BY MR. STEWART:
Q. I hand you Exhibit 34. And do you see that that is a document that has been sent to you by e-mail from a Dr. Sidney Schnoll? You're on the fourth line down.
A. I see myself as a recipient on the fourth line down.
Q. And can you just look at the document, is this a document that was sent to you that contains a RADARS system executive summary?
MR. PETRILLO: Just for the record, it looks like the document was sent originally by Brianne Weingarten and then forwarded by an Anthony Santopolo. It's a little different from the way you described it, but I don't think --
MR. STEWART: I see that's the way it was copied. Let me strike that.
BY MR. STEWART:

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Q. Do you see this is a document that was sent from Anthony Santopolo to you and others?
A. That is what I see.
Q. Initially I mischaracterized it.
Do you see that what Mr. Santopolo has done has sent you a RADARS System executive summary?
A. It looks like it.
Q. Do you recall getting an executive summary of the RADARS System while you were at Purdue?
A. I don't remember this.
Q. Is it fair to say that the RADARS system is something you became familiar with at Purdue?
MR. SNAPP: Object to the form.
A. It is fair to say that I knew about RADARS when I was at Purdue.
BY MR. STEWART:
Q. And you have no reason to think you wouldn't have been sent these materials while you were at Purdue?
A. I would have no reason to dispute.
(Whereupon, Purdue-Wright-35 was marked for identification.)

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BY MR. STEWART:
Q. I'm going to hand you Exhibit 35. Do you see that you've got in front of you an e-mail to you, looks like from a person named Schmidt?
A. Yes.
Q. Do you see it is entitled "CPDD Symposium Publication"?
A. Yes.
Q. And are you familiar with this publication?
A. Well, CPDD is the College on Problem of Drug Dependence, and they have a variety of venues in which publications are presented.
Q. Do you recall providing materials to CPDD relating to your discussions at a symposium?
A. I remember Bill Schmidt wanting something. I don't -- I'm not real clear on what I did.
Q. Do you see that he says "Thanks to everyone who submitted a summary of their presentation to be included in the summary of our symposium on 'New Approaches to Non-Addictive Analgesics.' This will be

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published as part of a NIDA Research Monograph early next year."
Do you see that?
A. Yes.
Q. Does that refresh your recollection that he was contacting you to get a summary of your presentation so he could put it in a publication?
A. It is what it says.
Q. And can you turn to the page of this document, this exhibit which is Exhibit 35, that ends -- that has a Bates stamp ending in 4827?
Do you see that?
A. Yes.
Q. Do you see it's got your name with a colon, and it's got a series of comments?
A. Yes.
Q. And if you want to look at it for a moment and tell me if you generally remember presenting these comments.
A. Well, I remember now because I remember the title.
(Witness reviewing document.)
Q. I've highlighted a portion, sir, and you can see it on the board, which is the second

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paragraph, and it starts with the word "Most." I wondered if you could read those first two sentences into the record.
A. Sure. "Most physicians agree that iatrogenic addiction is an uncommon event in the clinical management of acute pain states, with an incidence of perhaps 1 in 10,000 patients treated. Being so uncommon, it is assumed to represent a negligible risk. This is a grave error. Iatrogenic addiction ceases to be a rare and negligible problem as soon as the size of the acute opioid analgesic market is taken into account."
Q. Is that something that you would have stated at a symposium like this?
A. Yes.
Q. And is this consistent with your views even today?
A. Yes.
MR. SNAPP: Object to the form.
BY MR. STEWART:
Q. Have you looked at studies in recent years analyzing the correlation between treatment with long-term opioid therapy and abuse and addiction?

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A. No.
Q. So you haven't analyzed whether or not more recent studies have determined that there's a much higher risk of abuse and addiction?
MR. SNAPP: Object to the form.
A. I don't know what the recent studies show.
BY MR. STEWART:
Q. We just have to ask someone else about that?
A. You have to ask somebody else about that.
Q. What you were saying here is, look, even if you assume that the risk per human is quite low, the risk for all patients being treated with opioids leads to a significant number?
A. Number.
Q. Is that fair?
MR. SNAPP: Object to the form.
A. I agree that if you have a large denominator, even a low risk means a large number of people.
BY MR. STEWART:
Q. And do you see here that you identify

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in your talk the significant denominator by saying "There are about 130 million prescriptions written for oral medications containing oxycodone, hydrocodone, hydromorphone and propoxyphene every year"?
A. Propoxyphene.
Q. Thank you.
And the point is you point out, am I correct, that given that huge denominator you have a significant risk of thousands of new addicts each year?
MR. SNAPP: Object to the form.
A. Given those numbers in that hypothesis, yes. The problem is I don't know if it's true.
BY MR. STEWART:
Q. You say you don't know if it's true. Why do you say that?
A. The whole -- the paragraph says if it's this rate and you have this many people you could have -- you could potentially have this many addicts or abusers. To make that useful you need to have some idea of the numbers.
Q. And let me just ask you to read into the record the statement that you stated at this

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symposium starting with the words "There are about."
A. I lost it.
Q. It's right after the pink highlight on the materials that I gave you.
MR. SNAPP: Object to the form.
A. "There are about 130 million prescriptions written for oral medications containing oxycodone, hydrocodone, hydromorphone and propoxyphene every year. If even 1 in 10,000 patients (1 in 10,000) a year develops de novo addiction as the result of such treatment, this means 13,000 new addicts" per year.
BY MR. STEWART:
Q. I take it that's the statement you made to the symposium and allowed to be published?
MR. SNAPP: Object to the form.
A. Yes.
BY MR. STEWART:
Q. You're not backing away from that statement?
A. I'm just saying that those were theoretical numbers, that I took the best

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numbers I had at the time. Those numbers certainly have probably changed.
Q. Okay. Point is they're not really theoretical numbers so much you took the best numbers you had at the time, fair?
A. Fair.
Q. Do you see on the fourth paragraph down there's a statement that you make about street value? I'd ask you to read the first two sentences of that paragraph into the record.
A. "The street value (the amount a stranger in a bar will pay for a tablet) of diverted opioids is substantial, ranging from $1 up to $20 per tablet (prices vary depending on the strength, desirability, and the current supply). Given that the cost of most common opioid analgesics is less than $0.50 a tablet, there is substantial profit in diversion and resale, at all levels (manufacturer, wholesaler, retail pharmacy, physician and patient)."
Q. And this is what you presented at the symposium, fair?
MR. SNAPP: Object to the form.
A. Fair.
BY MR. STEWART:

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Q. And actually, you've stated this in many different ways we've read today, you've warned of your concern that these opioids like OxyContin have a significant street value and are subject to diversion?
MR. SNAPP: Object to the form.
A. I have said that multiple times today.
BY MR. STEWART:
Q. Now, we're talking about iatrogenic addiction. I'm curious, do you remember testifying earlier today that when you were at the FDA you made it clear you did not want to see OxyContin indicated for osteoarthritis?
MR. SNAPP: Object to the form.
A. I did not want to see OxyContin indicated for osteoarthritis.
BY MR. STEWART:
Q. Did the FDA ever change its position on that, that you know of?
A. I don't know what the FDA has done.
Q. Let me say it this way. While you were at Purdue still involved with opioids, did you ever become aware that the FDA had said it's fine to use OxyContin for osteoarthritis? Did the FDA -- strike that. Start a new question.

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Did the FDA, while you were at Purdue, ever tell Purdue it is okay to say that OxyContin is indicated for osteoarthritis?
MR. SNAPP: Object to the form.
A. I have no idea.
BY MR. STEWART:
Q. That wasn't in your area of concern at Purdue?
MR. SNAPP: Object to the form.
A. I might have considered it in my area of concern, but that didn't mean I knew about it.
BY MR. STEWART:
Q. Let me ask you this. When you were at Purdue, did you ever check to see whether Purdue salespeople were, in fact, promoting OxyContin for osteoarthritis?
A. No.
Q. Why not?
A. I had three drug development programs to run, and I was busier than could be. I didn't have time for looking at anything else.
Q. Who was the person at Purdue, if you know, who would have been in charge of analyzing what salespeople were representing with respect

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to proper uses of OxyContin?
MR. SNAPP: Object to the form.
A. That would have been a function in the marketing department.
BY MR. STEWART:
Q. More broadly, do you remember earlier today you testified that the FDA found that OxyContin, it wasn't any better than the existing opioid therapy, except that it had a different dosing, fair?
MR. SNAPP: Object to the form.
A. Not quite right. That the clinical trials that were submitted showed no competitive superiority to immediate-release oxycodone.
BY MR. STEWART:
Q. Did you ever, when you went to Purdue, take any steps to determine whether or not Purdue's sales force was marketing OxyContin in ways that were inconsistent with your determination at the FDA?
A. No, I did not, sir.
Q. Is the reason the same that you gave before, that you were working on other things?
MR. SNAPP: Object to the form.
A. The same reason, I was fully occupied

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with the duties that I'd been assigned.
BY MR. STEWART:
Q. I'm going to hand you Exhibit 36.
(Whereupon, Purdue-Wright-36 was marked for identification.)
BY MR. STEWART:
Q. And I'd like, sir, to ask you if you recognize this.
(Witness reviewing document.)
A. I don't remember writing the document, but it looks very much like a Curt Wright document.
Q. And do you see that on the front of the document that is Exhibit 36 you've got a page that's marked 4640, that's the last four digits of the Bates number?
A. Yes.
Q. It's the very front.
MR. PETRILLO: Front page. Have you got it?
BY MR. STEWART:
Q. Do you see -- by the way, we've talked about Bates numbers, just so the record is clear I take it you understand that a Bates number is this number that's at the bottom right-hand

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corner that we use to indicate what page we're on? Do you see that?
A. Yes.
Q. That's what a Bates number is, right?
A. Mm-hmm.
Q. So here we're at Bates number 4640. Do you see that this document was sent from you to Mr. Santopolo?
A. Yes, I do.
Q. Okay. And it looks like materials that you prepared to get Purdue ready for its OxyContin FDA negotiations.
Do you see that?
A. Yeah, I'm not sure about that.
Q. Okay.
A. I said earlier today that people would ask me questions, they'd say what would likely happen if -- about this or about that or about the other. I don't know if this represents my advising Tony on specific negotiations or writing another thought piece as to what could happen.
Q. Do you see, if you turn to Page 4641, that the heading of the document is entitled "OxyContin FDA Negotiations Issues Document"?

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A. Yes.
Q. And do you see that the way this document is broken out is you list the FDA -- for a series of issues you list the FDA unilateral position worst, and then Purdue's position best, and then you predict an outcome?
A. Yes, I do.
Q. And do you see that, for example, on the Page 4642 there's a section on advertising?
A. Yes, I do.
Q. And do you see that you warn that "The agency will take the position that part of the problem with diversion is due to an inappropriately large denominator of usage due to promotion of the drug for the management of non-malignant pain"? Do you see that?
A. I see that.
Q. Is what you're warning there, you're saying the FDA will say one of the problems is that OxyContin is being prescribed for too broad a series of conditions and that is leading to diversion, isn't that how you're articulating the challenge by the FDA?
MR. SNAPP: Object to the form.
A. Yes, I am, sir.

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BY MR. STEWART:
Q. Why do you think that's -- why was that your prediction of the position the FDA would take?
MR. SNAPP: Object to the form.
A. Earlier today I talked about a paper that we did that looked -- that said the more drugs in the pipeline, the more diversion you're going to get. I was very proud of that paper because Nab Dasgupta was finally to prove -- was able to prove something that I believed to be true. I believed this to be true, the more people are -- and I think other people at the FDA believed it, too, the more drug is being used the more diversion you're going to have. That's what I said.
Q. But what you recommended Purdue's position would be -- or strike that.
What you warn is that the FDA, because of that causal linkage between prescribing and diversion, would restrict promotion to oncologic usage?
A. It could do that.
MR. SNAPP: Object to the form.
BY MR. STEWART:

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Q. The FDA warning could say, look, we're just going to let OxyContin be a cancer drug, not a general use drug, fair?
MR. SNAPP: Object to the form.
A. That is what that sentence says.
BY MR. STEWART:
Q. And you're proposing that Purdue, though, urge a different tack, which is merely modification of promotion material to promote OxyContin as a WHO step two drug along with provision of non-product specific materials on control of misuse, abuse, and diversion, fair?
MR. SNAPP: Object to the form.
A. I'm not sure that's what I'm advocating, but I'm saying that's what could be done.
BY MR. STEWART:
Q. Okay. And do you know what was done with these materials that you provided?
A. I have no idea.
Q. Was there anyone at Purdue at the time this document that is Exhibit 36 was written that had better knowledge of the inner workings of the FDA --
MR. SNAPP: Object to the form.

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BY MR. STEWART:
Q. -- than you?
MR. SNAPP: Object to the form.
A. You're asking two questions, and they're difficult because after I left the FDA there were large, large changes in the division, and the new -- I already knew that the new division director had different opinions than I did, so I could not be sure what they would do. And I found that many 20-year experienced regulatory affairs professionals in all companies tended to be dismissive of my opinions because they believed they knew their business better than I.
BY MR. STEWART:
Q. So it sound like you thought you probably had the best understanding of the FDA within the company, but you felt like others also felt like they had expertise, fair?
A. That's fair.
Q. I'm going to hand you Exhibit 37.
(Whereupon, Purdue-Wright-37 was marked for identification.)
BY MR. STEWART:
Q. And I want you to look at it and tell

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me whether you recognize it. I'll tell you it may be two documents combined. Do you see the page marked 7492 --
(Witness reviewing document.)
Q. -- which is the second page of the document after the cover page?
A. Yes.
Q. Do you recognize that as an agenda for OxyContin abuse diversion meeting?
A. That's what it's labeled.
Q. Is that your writing on there, the handwriting?
A. I don't think so.
Q. Okay. Do you know if you attended a meeting about OxyContin abuse diversion in February of 2001?
A. I don't know.
Q. At Purdue did you use a calendaring system like Outlook, something like that?
A. I don't think so, but I can't remember.
Q. Do you think your secretary kept a paper calendar?
A. I don't know what -- I don't know.
Q. How were meetings -- how would you be

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notified of a meeting that you had to go to, was that by e-mail typically?
A. I believe it was almost always by e-mail.
Q. Do you remember attending meetings with Purdue, other Purdue employees to strategize about an OxyContin abuse diversion meeting coming up with the FDA?
MR. SNAPP: Object to the form.
A. I don't know whether I did or not. I was for a brief period of time attending a couple of meetings on abuse and diversion, and then Dave Haddox took over. So it's entirely conceivable I could have, I just can't remember.
BY MR. STEWART:
Q. Let me hand you a document marked Exhibit 38.
(Whereupon, Purdue-Wright-38 was marked for identification.)
BY MR. STEWART:
Q. And do you recognize that as a PowerPoint presentation that you sent Mr. Santopolo on March 30th, 2001?
A. I certainly recognize it as a PowerPoint presentation. I believe I authored

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it, I don't know if I was the sole author. And the header says that I sent it on 3/30/2001.
Q. And turn to the first page of the materials. Do you see that we have no page numbers on these pages of this PowerPoint?
A. There are no page numbers.
Q. Okay. Well, if you'll -- I'm going to refer to pages by the headings. Do you see that if you turn to the first page there's a slide entitled "The OxyContin Crisis"?
A. Yes.
Q. And do you see that the center bullet point says "OxyContin has been reported as having a high rate of criminal misuse, abuse and diversion"?
A. Yes.
Q. That wasn't controversial at this time by the time this was distributed, fair?
MR. SNAPP: Object to the form.
A. Not to me.
BY MR. STEWART:
Q. Can you turn to the next page of Exhibit 38, and tell me if you've arrived at a slide entitled "The OxyContin Crisis," the second slide?

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A. Yes.
Q. And is the middle bullet a bullet that says "PPLP strongly believes that the public will be best served if the company works in a responsible, proportional and coordinated manner with the appropriate governmental and non-governmental agencies to bring a quick resolution to the problem"?
A. Yes.
Q. Was that the approach that Purdue took with the FDA, that it would be a cooperative partner in addressing the diversion of OxyContin?
MR. SNAPP: Object to the form.
A. My -- I do not remember this. I mean, I remember something like this, but I do not remember the specifics. I believe this may be what I told Tony Santopolo what Purdue should do.
BY MR. STEWART:
Q. Do you know whether Purdue led the FDA to believe that it was going to work in a responsible, proportional and coordinated manner with the FDA and other appropriate governmental and non-governmental agencies to bring a quick

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solution to the problem of diversion of OxyContin?
MR. SNAPP: Object to the form.
A. I was not on the OxyContin team, and I don't know.
BY MR. STEWART:
Q. Can you turn until you find a page of this PowerPoint that is Exhibit 38 that's entitled "What could be done?"
A. I have found that page.
Q. Okay. Do you see that the last bullet says "Fortunately, PPLP" -- that is Purdue -- "has been preparing for this kind of problem ever since we first became aware of rumors of OxyContin abuse"? Do you see that?
A. I see that.
Q. What sort of preparation had Purdue been doing?
A. It first formed a committee. That was the committee I attended that was very early. It then hired, I believe new hired someone in -- whose expertise was diversion, criminal diversion. It then hired Dr. Haddox. It then hired Dr. Schnoll. It then built my entire department. And it also put muscle behind the

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Opioid X program.
Q. Can you turn to the page in Exhibit 38 that's entitled "What Has Been Done?"
A. I have found that page.
Q. Do you see that the third bullet says "This response must include appropriate modifications to labeling, marketing, promotion, provider education and regulation, as well as modifications (if possible) to the actual dosage form"?
A. I see that, sir.
Q. Are you describing here what Purdue can do to address the outbreak of diversion of OxyContin?
A. I am describing what Purdue could do.
Q. Did you say that you're not familiar with the guilty plea entered by Purdue and three top executives in 2007 for misbranding OxyContin?
A. I only know that it existed.
Q. So we'd have to look at that guilty plea to determine whether the actions in the guilty plea are consistent with the response that you're suggesting, fair?
MR. SNAPP: Object to the form.

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A. I don't understand.
BY MR. STEWART:
Q. Sure.
To determine whether or not all the actions that are listed in Purdue's guilty plea are consistent with modifications to labeling, marketing, promotion, and so forth to address the diversion problem, we'd have to compare what you're proposing to the guilty plea, fair?
MR. SNAPP: Object to the form.
A. I'm not sure the -- since I don't know what the guilty plea was --
BY MR. STEWART:
Q. Fair enough.
A. -- I can't answer that one.
Q. I hand you Exhibit 39.
(Whereupon, Purdue-Wright-39 was marked for identification.)
BY MR. STEWART:
Q. I'm going to hand you Exhibit 39. Do you have it?
A. I have that.
Q. Do you see it's an "Agreed Statement of Fact," that's the title? Do you see that?
A. I see that.

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Q. And I take it you're not familiar with this document?
A. I am not familiar with this document.
Q. And I'll tell you what, can you turn to Page 6 of 16? The pages on the document have their own internal pagination. Do you see that?
A. Yes.
Q. Do you see there's a subparagraph B?
A. Mm-hmm.
Q. I take it if Purdue sales representatives were telling healthcare providers that OxyContin potentially creates less chance for addiction than immediate-release opioids, that would not be marketing that would help reduce diversion, fair?
MR. SNAPP: Object to the form.
A. Okay. But I do need one piece of information.
BY MR. STEWART:
Q. Sure.
A. When was this supposed to have happened?
Q. And I'll just tell you, if this happened in the period that you're creating this PowerPoint, that would be inconsistent in 2001

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with what you're suggesting, fair?
MR. SNAPP: Object to the form.
A. It would be inconsistent -- in my PowerPoints, speaking as somebody in the abuse of -- the group that was concerned passionately with abuse, I made a number of suggests that Purdue should do, and I'm aware that it will take a certain amount of time to implement it, to agree to a suggestion, then implement a suggestion. So I simply don't know what time period we're talking about.
If -- had someone asked me do you think we're -- these are adequate changes to deal with abuse and diversion, changes in the label, changes in the detailing materials, I would have looked at that. I'm not happy today that if these agreed -- if this is a statement of fact and they were telling people that this has less abuse potential than immediate-release opioids, I'm not happy that they were doing that.
Q. Turning back to Exhibit 38, which is this PowerPoint.
A. Yes.
Q. Do you see that? Do you see that

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there's a page in Exhibit 38 entitled "What Can The Sponsor Do"?
A. Yes, there is.
Q. And do you see on the second bullet says Purdue -- PPLP in this presentation is Purdue, fair? Is that correct?
A. PPLP is one acronym for Purdue.
Q. And you're saying "Purdue has to," and then you have a colon, and you list seven things that should be done, is that correct?
A. That is correct.
Q. And do you know if Purdue carried out your recommendations with respect to these seven items that are on Exhibit 38, the page entitled what can the sponsors -- "What Can The Sponsor Do?"
MR. SNAPP: Object to the form.
A. They carried -- to my knowledge, which is limited to where I was working and what I was doing, they carried out a number of them.
BY MR. STEWART:
Q. Let me ask you, today as you look at this, do you still believe that your list of items, things that should be done to reduce diversion of OxyContin, was a good list? Was

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this the list of things that Purdue should have done?
MR. SNAPP: Object to the form.
A. I believe that is a list of things that should have been done.
BY MR. STEWART:
Q. Okay. Can you turn to a page entitled -- a page of Exhibit 38 entitled "Modify the marketing of our products"? Do you see that?
A. Modify the labeling of such products to aid the prescriber.
Q. I'm looking at something that says "Modify the marketing of our products (to center on appropriate patient selection)."
Do you see that?
A. I see that.
Q. Do you see the second bullet says "PPLP" -- Purdue -- "could do more to encourage proper usage and discourage misuse of our products."
Do you see that?
A. Yes.
Q. What was your belief, what were they not doing that Purdue needed to do more of?

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A. I thought they were marketing with respect to the label. I thought they needed to market in a more stringent way.
Q. And where did you have the impression that more stringent marketing methods were needed?
MR. SNAPP: Object to the form.
A. Because that's what you do. I mean, just believed at the time that that's what would help.
BY MR. STEWART:
Q. And I guess what I'm getting at is, it sounds like you had information that Purdue was not doing enough to encourage proper usage and discourage misuse of our products. Am I reading that correctly?
MR. SNAPP: Object to the form.
A. I did not have such information, I don't think.
BY MR. STEWART:
Q. So this was a surmise in your mind?
A. This was a surmise.
Q. Can you turn now finally to a page entitled "Integrated Risk Management"? Do you see that?

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A. I have it.
Q. Do you see again we're on the exhibit that is Exhibit 38, and now we're on a page entitled "Integrated Risk Management"? Do you see that?
MR. PETRILLO: Yes, right.
A. I think I'm in the right place.
BY MR. STEWART:
Q. And do you see the third bullet says "In settings where there is high patient turnover, increased geographic or regional risk, unusual volume of narcotic use or other risk factors, it is safer for the provider to use narrow-spectrum, low diversion risk, or tamper-resistant medications."
Do you see that?
A. I see that.
Q. So at that time that you produced this, OxyContin was not a narrow-spectrum, low diversion risk, or tamper-resistant medication, fair?
A. That is true.
Q. What you're saying is instead of using a drug like OxyContin that doesn't have these characteristics, you probably in these settings

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want to dial back and use a drug that's less susceptible to diversion, fair?
MR. SNAPP: Object to the form.
A. If you're in a hotspot and things are going badly, you want to change what you're prescribing.
BY MR. STEWART:
Q. I hand you an exhibit marked Exhibit 40.
(Whereupon, Purdue-Wright-40 was marked for identification.)
BY MR. STEWART:
Q. I'd ask you to tell me if you recognize that document.
A. This appears to be a Regulatory Agency Contact Report of a conversation with Dr. Cynthia McCormick, division director of my old division.
Q. And do you recall whether or not you were made aware at the time of this contact? And I'll point out that you're copied on this document on the next page which is marked 6255 with a Bates number.
(Witness reviewing document.)
Q. Do you remember that?

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A. I don't remember this document.
Q. Okay. Do you remember hearing about -- do you see that the document states on the first page that "Dr. McCormick started out" -- and I've got it highlighted here on the screen -- "started out the discussion by stating that she was concerned about a recent press release (Attachment 1) that had been received by the Agency's press office for review."
Do you see that?
A. Yes.
Q. And do you see then that on the fourth paragraph down, or third I should say, Dr. McCormick says, or the document recounts, "Dr. McCormick stated that she felt the issues discussed at the April 23 meeting were much more serious than what was written in the press release; in particular, that we did not talk about the problems specifically relating to OxyContin, rather, that it only addressed prescription drugs in general."
Do you see that?
A. Yes.
Q. Do you remember this back and forth?
A. I do not remember this.

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Q. All you can do is identify this as a document that you would have received a copy of, is that fair?
MR. SNAPP: Object to the form.
A. Yeah.
BY MR. STEWART:
Q. I'm going to hand you a document marked Exhibit 41.
(Whereupon, Purdue-Wright-41 was marked for identification.)
BY MR. STEWART:
Q. I'd like to know if you recognize this document as an e-mail sequence.
(Witness reviewing document.)
Q. And I direct your attention, in fact, that your name comes up in the second e-mail down on the page marked 1719 of Exhibit 41.
Do you see that?
A. Mm-hmm.
Q. Do you see where Dr. Richard Sackler says, "Robert, Bob, Mike, I, and Curtis Wright were all involved in the past and had a lot to do with the quality of the PI. It would be good for their knowledge to be tapped for this, the most critical rewrite that we have ever had."

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Do you see that?
A. Mm-hmm.
Q. Who is Richard Sackler?
A. Richard Sackler is one of the owners of the company.
Q. And at this time did he have an official position?
A. I'm not -- I'm not sure what his position was at that time.
Q. I take it you've talked with Richard Sackler a number of times, fair?
MR. SNAPP: Object to the form.
A. A couple of times.
BY MR. STEWART:
Q. He sent you e-mails on subjects related to Purdue at different times?
MR. SNAPP: Object to the form.
A. I'm not so sure. I don't know if he sent me e-mails.
BY MR. STEWART:
Q. Do you know what he's talking about here when he says "Robert, Bob, Mike, I and Curtis Wright were all involved in the past and had a lot to do with the quality of the PI"? Do you know what's he's referring to?

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A. I think he means the original package insert for OxyContin.
Q. And he's saying you all were all involved in that process, fair?
A. Yeah.
Q. And that's accurate?
A. I was with the Food and Drug Administration, I reviewed it.
Q. And who are Robert, Bob, and Mike that he's referring to?
A. Robert would be Robert Reder. Mike would be Mike Inn -- I'm not sure how to spell his name.
Q. What role did he play?
A. I don't remember.
Q. Okay. And Bob?
A. Bob Kaiko.
Q. Okay. And Dr. Sackler himself was involved in that process with respect to the original package insert?
MR. SNAPP: Object to the form.
A. It says it here. I don't know.
BY MR. STEWART:
Q. Did you ever have conversations with Dr. Sackler himself when you were at the FDA

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regarding the package insert?
A. No.
Q. I hand you Exhibit 42.
(Whereupon, Purdue-Wright-42 was marked for identification.)
BY MR. STEWART:
Q. Sir, I hand you an exhibit and ask you if you recognize it.
(Witness reviewing document.)
A. I do not remember specifically writing the document. It is almost certainly my authorship, and it looks like a thought piece I wrote for Sally Riddle.
Q. And do you know if it was ever published?
A. I don't think it was ever published.
Q. And do you remember writing this thought piece?
A. I remember thinking these thoughts. I didn't remember the thought piece until I looked at it.
Q. Tell me about the tipping point. What is the tipping point that you were referring to in this article?
MR. SNAPP: Object to the form.

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A. The way I describe it in this article is that economic forces drive diversion of pharmaceuticals. Diversion of pharmaceuticals results in their being used for abuse and diversion -- I mean, used for abuse. As cases of abuse grow, you eventually reach a tipping point where it becomes a crisis and you have to do something immediately to try to control the crisis.

BY MR. STEWART:

Q. And what characterizes the tipping point?

A. Well, I've forgotten. The tipping point, as I describe it here, if I am correct, is when diversion and abuse have resulted in enough cases so there is sufficient media attention, publicity, press reports, internet traffic, peer-to-peer communication so that the abuse of the drug explodes.

Q. I think you've stated that today we continue to be in a period of our national history where the abuse of opioids is a major social problem, fair?

A. Every opioid, yes.

Q. When did -- when was the tipping

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point, in your mind, reached for this current cycle of abuse and diversion of opioids in the United States?

MR. SNAPP: Object to the form.

A. Can I look up one of my publications?

BY MR. STEWART:

Q. Certainly.

A. If I can find it. I haven't thought about this in years.

(Witness reviewing document.)

A. I would say between 2000 and 2002.

Q. And you've talked about opioids generally. That would certainly include OxyContin, fair?

A. Fair.

Q. I'm going to hand you an exhibit, Exhibit 43.

(Whereupon, Purdue-Wright-43 was marked for identification.)

BY MR. STEWART:

Q. I'd like to know if you recognize this document.

(Witness reviewing document.)

A. It looks like another thought piece by Curt Wright.

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Q. And can we assume that this is a thought piece that you sent on June the 10th, 2003 to all the various folks that are on this e-mail chain, including Dr. Haddox?

A. Haddox, Schnoll, Kramer, Douglas Kramer, Alton Kremer, Lynn, yeah, I assume I sent it to them.

Q. I'm going to hand you another document marked Exhibit 44.

(Whereupon, Purdue-Wright-44 was marked for identification.)

BY MR. STEWART:

Q. And ask you if you recognize it as a deposition transcript of a deposition taken of you in February, 2013.

(Witness reviewing document.)

A. It's what it's so labeled.

Q. Do you remember giving a deposition on February the 13th, 2013?

A. I remember giving several depositions, but I don't remember much of them.

Q. Any reason to think that you, looking at this document -- well, I'll ask you this.

Looking at this document, does it refresh your recollection that, in fact, on

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February 13th, 2013 you gave deposition testimony?

A. I still don't know which one it was, but I can't -- there's no reason to dispute the record.

Q. And I take it if you testified in a deposition, we can assume that you tried to testify accurately and truthfully?

A. I have always tried to testify accurately.

Q. And that would be true for this deposition, the transcript of which we have as Exhibit 44, fair?

A. I was sworn under oath, so I told the best truth I knew.

Q. I'd just like to ask you about one page in the deposition. Could you turn to Page 181?

MR. PETRILLO: It may not matter, Counselor, but are you representing you have all the pages of the transcript in this exhibit?

MR. STEWART: Yes. If there's a missing page, we'll be happy to replace it.

A. I found Page 181 of the transcript, I believe.

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BY MR. STEWART:
Q. Do you see that you state -- you're looking at a document, but you state, and I don't have that document for you, that, and this is the second paragraph down, "the problem that if an abuser wants to take, wants to get high, they can take an intact dosage form of a high enough strength, if they can get it, to get high without having to crush the product at all."
Do you see that?
A. I see that.
Q. Is it fair to say that's your view, that's correct?
MR. SNAPP: Object to the form.
A. I'm not sure it's my view anymore. There have been events that have taken place since that time that suggest to me that it takes less tamper-resistance than I thought to deter diversion and abuse of a particular dosage form.
BY MR. STEWART:
Q. I'm curious, what's brought you to that belief?
A. After I left Purdue they changed the formulation to something that approximated one of the Opioid X formulations, and some years

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later I got an e-mail from a friend, and I don't remember who sent it to me, saying hey, look, it worked, and I saw that in that particular study the new formulation had reduced overdose deaths by 80 percent.
Q. Do you remember that study you're talking about?
A. I'm sorry, I don't.
Q. And I take it -- we've talked a little bit today about trends and diversion, those sorts of things, but when you're providing this testimony right now you're not really basing it on the fact that you actually reviewed literature to suggest that there's a significant change, fair? In other words, you're not suggesting -- you're mentioning an anecdote about a communication with a friend?
A. That --
MR. SNAPP: Object to the form.
A. -- cited a scientific paper that I then looked at and was impressed by the reduction in overdose deaths.
BY MR. STEWART:
Q. I guess what I'm getting at is, though, first of all, you're not -- when you

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were characterizing in 2013 deposition, when you were saying "if an abuser wants to take, wants to get high, they can take an intact dosage form of high enough strength, if they can get it, to get high without having to crush the product at all," you do believe that's correct?
A. That is true.
MR. SNAPP: Object to the form.
BY MR. STEWART:
Q. Okay. I'm going to hand you another document that I'll mark as Exhibit 45.
MR. PETRILLO: If we're going to go for another half hour, maybe take a short break, or do you think you're almost done?
MR. STEWART: No, I think we should take a short break if you'd like.
THE VIDEOGRAPHER: We are now going off the record, and the time is 5:49 p.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 5:56 p.m.
MR. PETRILLO: Can we start without your colleague?
MR. BENNER: We can start.
BY MR. STEWART:

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Q. Dr. Wright, I'm going to hand you Exhibit 45.
(Whereupon, Purdue-Wright-45 was marked for identification.)
BY MR. STEWART:
Q. Do you recognize that exhibit as a transcript of a deposition you gave on January 15th, 2014? And it's intended to be a complete transcript.
(Witness reviewing document.)
A. This looks like the deposition I gave in Boston.
Q. And is it fair to say that when you gave this deposition, for which Exhibit 45 is the transcript, that you tried to testify truthfully and accurately?
A. Yes, sir.
Q. Now I'm going to hand you deposition excerpt 46.
(Whereupon, Purdue-Wright-46 was marked for identification.)
BY MR. STEWART:
Q. This is not a transcript of your deposition. It's a transcript of a deposition by a Robert Reder.

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Do you see that?
A. Excuse me, at the top it says that this contains confidential information. Is it proper for me to read this?
Q. It is.
And do you -- can you identify Robert Reder?
A. Robert Reder was my superior at Purdue. He was one of the leading physicians at Purdue Pharma, later left and went to Endo.
Q. And can you tell me, I'm going to -- if you turn to Page 25 in the deposition, and this is an excerpt, it's not the entire transcript, do you see, and I've highlighted the material, that the deposition reads -- the question in part is "in December 1994, that no specific studies of the OxyContin formulation had been conducted to ascertain if it had a lower abuse potential"? Do you see Dr. Reder says "that's correct"?
A. I see that.
Q. Do you agree with that?
A. That's correct.
Q. Do you see then that there's a question, "Did Purdue ever do any specific

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studies to ascertain whether or not OxyContin had a lower abuse potential than, say, morphine?" And he answers, "You mean...comparative studies?" The questioner says "Yes." And then he answers "No."
Do you see that?
A. Yes, I see that.
Q. Do you share that view?
A. To the best of my knowledge, that's true.
Q. Final question was in this deposition, "What about immediate-release oxycodone products?" And he answers "No."
Do you see that?
A. Yes, I see that.
Q. Do you agree with that as well?
MR. SNAPP: Object to the form.
A. I'd have to think about that one and look at the data. And I simply cannot remember because it was too long ago. I -- I'm not sure there isn't data available. He is correct when he says they did not do head-to-head abuse liability trials in post addicts, which are the conventional -- which is the standard, gold standard.

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BY MR. STEWART:
Q. Now, sir, we talked about -- and you can set that exhibit aside. We talked about Richard Sackler. I think you identified him as the owner of -- one of the owners of Purdue, fair?
MR. SNAPP: Object to the form.
A. I do not know Dr. Richard's exact title. He and the Sacklers -- the Sackler family and that group of Sacklers owned the company.
BY MR. STEWART:
Q. Who are the Sacklers that you know of that own the company?
MR. SNAPP: Object to the form.
A. Well, that's difficult because a lawyer once told me that there's one guy in Switzerland who knows how the companies are organized, and he's never coming to the United States. And I don't -- you're asking the wrong guy about the financial ownership of Purdue, the Purdue-associated companies.
BY MR. STEWART:
Q. On the description, fair enough.
I take it you don't know the name of

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the guy in Switzerland?
A. No, I'm not sure he's in Switzerland.
Q. Do you remember who told you that about this fellow in Switzerland?
MR. SNAPP: Object to the form.
To the extent -- you said it was a lawyer. If it was a Purdue lawyer, I'm instructing you not to answer on the grounds of attorney/client privilege if it took place during the time that you were at the company.
BY MR. STEWART:
Q. The only question I have for you to explore that, and I don't want you ever to tell me anything that you told a lawyer, but I take it it is true that that was told to you by a lawyer? Or now, let me step back for a minute.
MR. STEWART: You've made your objection, we can address it. I'll withdraw the question.
BY MR. STEWART:
Q. Tell me, you mentioned two social occasions that you'd interacted with Richard Sackler, can you describe those social occasions?
MR. SNAPP: Object to the form.

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A. Well, they would have been at the presentations which we made to the company and to the family, and I said hello to him.
BY MR. STEWART:
Q. Tell me about that. What presentations are you talking about?
A. I do not know if it was annually, I do not know if it was -- what the frequency was, but I remember it because we were all going in to hear presentations on various wonderful things about the company, and the clinical department had to talk about the projects that we had in progress, and I sat down in what looked like a perfectly wonderful set of empty seats only to be shooed out of there because that was reserved for the family.
Q. And do you remember the time frame? Is this a single meeting that you remember, or were there multiple meetings like this?
A. I know of at least two.
Q. And were they similar meetings, the two meetings that you described?
A. They were similar meetings. They were progress meetings.
Q. And where would such progress meetings

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be held?
A. It's been too long. I don't remember. They were external. We went someplace else, but where exactly I don't remember.
Q. Put it this way. Was it in Connecticut?
A. Yes.
Q. You didn't fly somewhere?
A. No, it was in Connecticut.
Q. So you'd go off campus?
A. Rent a big hotel or a big hotel conference room, an auditorium large enough to hold all the people, and then we would present.
Q. And how many people would be present at these meetings that you're describing?
A. A bunch of employees. I mean, but I'm not good enough at crowd estimation to guess.
Q. Are you talking 20 or 50?
MR. SNAPP: Object to the form.
A. 200.
BY MR. STEWART:
Q. And other than those meetings -- do you remember what those meetings were called?
A. No, I do not, sir.
Q. Other than those meetings that you've

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just described, one more question about those meetings. Were they annual meetings do you think?
A. I'm not sure.
Q. Other than those meetings, have you ever had a social meeting with any member of the Sackler family?
A. No, I have not, sir.
Q. You've never had a meal with a Sackler family member?
MR. SNAPP: Object to the form.
A. I had -- yes, I did. I had -- when I was new to the company, part of introducing somebody new to the company was that you had lunch with the Sacklers and I had lunch with the Sacklers.
BY MR. STEWART:
Q. And how did that happen? Did that happen in the corporate headquarters?
A. Yes.
Q. And who was present?
A. Sacklers.
Q. Was Richard Sackler present?
A. I'm not sure which of the Sacklers were present.

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Q. Do you think Kathy Sackler was present?
MR. SNAPP: Object to the form.
A. I don't know if Kathy was present. I mean, at the time I was so overwhelmed and tired, I just said hello and good-bye, was polite, and that was my introduction to the Sacklers.
BY MR. STEWART:
Q. And was that -- how many people do you remember were in that lunch?
A. Five or six.
Q. And was that held in a particular dining room that you had?
A. There was a dining room that -- there was a Sackler family dining room in the old building.
Q. And was that the only time you ever ate in the Sackler family dining room?
A. It was, sir.
Q. Other than that, have you ever had a meal with a Sackler family member?
A. I don't think so. I can't remember any.
Q. Did you ever exchange communications

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with Richard Sackler about anything not related to work at Purdue?
A. I don't think so.
Q. While you were at Purdue, did you ever receive anything of value from an entity other than Purdue itself for work you were doing with respect to opioids?
MR. SNAPP: Object to the form.
A. I don't think so.
BY MR. STEWART:
Q. By the way, you talked about those presentations where there were, you know, a couple hundred employees. Did you yourself present at those meetings?
A. I don't think I ever did.
Q. Has a member of the Sackler family ever given you anything of value?
MR. SNAPP: Object to the form.
A. When I reached retirement age the company gave me a cuckoo clock, a clock.
BY MR. STEWART:
Q. Is that the extent of the list of things of value?
A. Yes, sir.
Q. I hand you Exhibit 47.

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(Whereupon, Purdue-Wright-47 was marked for identification.)
BY MR. STEWART:
Q. Do you recognize this document?
(Witness reviewing document.)
A. It looks like an e-mail I got, I was carbon copied on.
Q. Do you know why you're copied on this, this sequence of e-mails from Richard Sackler and others?
MR. SNAPP: Object to the form.
A. I don't know for sure, but I have a hypothesis.
BY MR. STEWART:
Q. What's that?
A. During a period of time, and I don't remember how long, I sat on the external product acquisition board that did scientific assessment of new product opportunities that were being peddled with Purdue.
Q. You think that's why you would have been included in this?
A. Most likely.
Q. I'm going to hand you a document marked Exhibit 48.

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(Whereupon, Purdue-Wright-48 was marked for identification.)
(Witness reviewing document.)
BY MR. STEWART:
Q. Do you recognize this document?
A. I remember the issue. I don't recognize the specific e-mail.
Q. So this is Dr. Sackler e-mailing you about the --
A. Yes.
Q. And what was the basic -- what was he inquiring about, as you recall?
A. If I'm right, because this was a long time ago, Algos Pain Therapeutics, or one of the other, was one of the companies that was presenting a new product acquisition to the committee, and it looks like Richard Sackler wanted to know what I thought about it.
Q. Is that pretty commonplace for him to reach out to you and try to get your thoughts on drug development and those sorts of subjects?
MR. SNAPP: Object to the form.
A. I didn't even know that he'd done it once. I mean, it was not a -- not regular in any way.

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(Whereupon, Purdue-Wright-49 was marked for identification.)
BY MR. STEWART:
Q. Let me hand you Exhibit 49. In your dealings with Dr. Sackler, did you feel, and in his dealings with you, that he was a person who spoke with precision?
MR. SNAPP: Is that a question?
MR. STEWART: Yes, that's a question.
MR. SNAPP: Object to the form.
A. Sorry, I'm still orienting myself to what this is. Oh, yeah.
BY MR. STEWART:
Q. I had a general question, is Dr. Sackler, he's a doctor, he's an executive, did he generally speak with precision when he was dealing with you?
MR. SNAPP: Object to the form.
A. I don't know what -- I couldn't characterize. It was so infrequent I couldn't characterize how he spoke.
BY MR. STEWART:
Q. How many times do you think you spoke to Dr. Sackler on the phone?
A. Twice.

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Q. Did Dr. Sackler tell you anything that was inaccurate? Maybe that's another way to phrase that.
MR. SNAPP: Object to the form.
A. Not that I know of.
BY MR. STEWART:
Q. Now, turning to this exhibit that is Exhibit 49, do you have that in front of you?
A. Mm-hmm.
Q. And if you're looking at the exhibit, do you know what it is? What's this communication?
A. Well, I think I know what it is. One of the intellectual property ideas that I presented to the intellectual property committee was for individualized automated pharmaceutical dispensing, compounding and dispensing for compounding pharmacies. Many factories have high volume pharmacy so that you could program the machine, instead of a pharmacist, to compound a specific product at a specific strength for a specific person.
Q. And I notice Dr. Sackler's been wrapped into this discussion here, is that fair?
MR. SNAPP: Object to the form.

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A. It looked like it was taken away -- I was taken out of it, and it was elevated to Dr. Sackler.
BY MR. STEWART:
Q. I hand you another document which I've marked as Exhibit 50. Do you see that?
(Whereupon, Purdue-Wright-50 was marked for identification.)
BY MR. STEWART:
Q. Do you see what that document is?
(Witness reviewing document.)
A. It looks like the same one.
Q. Does it seem like it's the exact same document?
A. I think so. I'm not sure.
Q. Let's set that aside.
(Whereupon, Purdue-Wright-51 was marked for identification.)
BY MR. STEWART:
Q. I hand you a document marked 51, ask you if you recognize that document.
(Witness reviewing document.)
MR. BENNER: Is this 50 or 51?
MR. STEWART: 51.
MR. BENNER: Did you skip 50?

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MR. STEWART: He had 50. It's 51.
BY MR. STEWART:
Q. Do you recognize what this document is about?
A. I'm trying to determine that. This looks like another new products evaluation e-mail chain document.
Q. We've seen a number of e-mails in which you are included in the materials being sent around, Dr. Sackler is included. And can we characterize most of these e-mails as e-mails in which you, he, and other top executives are talking about new products?
MR. SNAPP: Object to the form.
A. Thank you for the courtesy, but I was not a top executive with Purdue. I was simply on the new product committee because I'd done too many inventions, and so I would get a copy of the stuff, and I would review it, and I would go to the meeting, and then they would send -- it looks like they were sending me copies of all their opinions about it.
BY MR. STEWART:
Q. Is it fair to say that with respect to your company, Dr. Robert Kaiko, Michael

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Friedman, David Haddox, these were all high level executives in Purdue, fair?
MR. SNAPP: Object to the form.
A. I would characterize Paul Goldenheim, Dr. Richard, Bob Kaiko, Michael Friedman, and I would characterize Dr. Haddox as a high level executive by the end of his stay.
BY MR. STEWART:
Q. I'm going to hand you another exhibit marked Exhibit 52.
(Whereupon, Purdue-Wright-52 was marked for identification.)
BY MR. STEWART:
Q. Ask you if you recognize it.
A. It looks like an adverse event report.
Q. And was this sent by Purdue Pharma to you?
A. It was sent to the agency, and it would have come into the mailroom, and it would have gone to the consumer safety officer in charge, and if she wanted me to read it she would have given to me to read it, if she wanted me to give it to one of the other OxyContin reviewers she would have given it to them.
Q. Let me ask you, though, is it

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addressed directly to you, Curtis Wright, MD?
A. Yes.
Q. And so you were still at the FDA on March 25th, 1997?
A. Yes.
Q. Still processing materials from Purdue?
A. Yes.
Q. Now, I hand you an Exhibit 53.
(Whereupon, Purdue-Wright-53 was marked for identification.)
BY MR. STEWART:
Q. Ask you if you recognize it.
(Witness reviewing document.)
Q. If you'd look on the back page which is marked by the Bates number 2207, do you see there is a blurb about your leaving the FDA?
A. Yes, I do.
Q. And it says you're going to work at Adolor in Malvern, Pennsylvania?
A. Yes.
Q. Tell me, who owned Adolor?
A. Adolor was a venture capital pharmaceutical venture, so I don't know if it was owned by anybody.

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Q. Did you get stock when you went there?
A. I got stock when I went there.
Q. So you were an owner, weren't you?
A. I was an owner. I was a part owner.
Q. And who was the most senior person at Adolor that you were ever aware of?
A. I've forgotten his name. He was my boss. I forgot his name.
Q. He recruited you?
A. He recruited me. He was my boss. I've forgotten his name.
Q. Was that the president of Adolor?
A. Yes.
Q. And how many employees were there at Adolor when you worked there?
A. I have to count. I would say seven or eight.
Q. Where did Adolor get its funding?
A. I'm unclear what you mean.
Q. Well, were you paid a salary when you were at Adolor?
A. I was paid a small salary when I was at Adolor. I was mostly given stock.
Q. And what -- who did you -- if you were given stock, who did you understand was the

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primary shareholder in Adolor at the time you went there?
A. I didn't know who was the primary shareholder in Adolor.
Q. Who did you think was providing the money that went into your paycheck when you were at Adolor?
A. I didn't really know.
Q. Was Adolor in any way affiliated Purdue Pharma?
A. Not that I know of.
Q. Was Adolor affiliated in any way with any member of the Sackler family?
A. Not that I knew of.
Q. Can you name any other person who owned Adolor stock other than you?
A. Well, the president and business owner, the laboratory -- the chief scientist whose name I've forgotten, too, we all got it. We had stock options, and we had the ability to purchase stock at the option price, and I bought all of mine.
Q. Did they cash you out when you left?
A. I had to cash out when I left.
Q. Did you ever talk to anyone at Purdue

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about Adolor before you went to Adolor?
A. No, I don't think so.
Q. Did you, when you were still at the FDA, call Purdue and talk about going over to Purdue for a job?
A. When I was still at the FDA?
Q. Yes.
A. Absolutely not.
Q. I think -- strike that.
I ask you, it seems you're going from the FDA to a seven person company, can you tell me why you didn't figure out who the owners of the company were before you went there?
MR. SNAPP: Object to the form.
MR. PETRILLO: Objection.
A. It was my first job in private industry, and I was naive and inexperienced.
BY MR. STEWART:
Q. Can you look on that announcement in the e-mail chain and figure out what the date was that you went to Adolor?
A. September 29th.
Q. Now, do you see in this e-mail chain that Dr. Richard Sackler referred to your going to Adolor as bad news?

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A. Yes.
Q. Did he ever talk to you about that, why he thought it was bad news that you were going to Adolor?
A. No, but I'm not surprised.
Q. Why are you not surprised?
A. I was viewed as a particularly fair and effective FDA reviewer.
Q. Including by Richard Sackler, for example?
MR. SNAPP: Object to the form.
A. I would assume so.
BY MR. STEWART:
Q. I'm going to hand you copies.
(Whereupon, Purdue-Wright-54 was marked for identification.)
BY MR. STEWART:
Q. Now, do you see that this is an e-mail exchange from, it looks like, Bob Reder to a series of people at Purdue?
A. It looks like an e-mail from Reder to -- it looks like the usual suspects. I mean, it looks like the usual senior executives who might be involved in new product.
Q. And do you see that he says that he

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received a telephone call -- I'll just quote it. "I received a telephone call today from Dr. Curtis Wright, who was formerly of the FDA ODE3 and is now Vice President of Research for Adolor." He gives the address.
Do you see that?
A. Mm-hmm.
Q. Did I read that correctly?
A. You read that correctly.
Q. So he's saying that you called him. Do you remember making that phone call?
A. I don't remember making that phone call, but I have no reason to believe not.
Q. If Robert Reder said you made a phone call, he's a credible guy --
A. Yes.
Q. -- and that makes sense?
And you were reaching out to discuss the possibility of cooperation between Adolor and Purdue on a product?
A. Peddling our wares.
Q. Okay. Do you see that the date of this is 10/7/97?
A. Mm-hmm.
Q. So does this reflect your calling

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Robert Reder at Purdue less than ten days after you've left the Food and Drug Administration?
A. Probably.
MR. PETRILLO: Objection to form.
BY MR. STEWART:
Q. How -- while you were at Adolor, what did you -- what was your interaction with Purdue?
A. I don't think we -- I don't think we had any interaction. I don't think they bid on any of our portfolio.
Q. So you would have reached out to them, though, on other occasions?
MR. SNAPP: Object to the form.
A. I would have reached -- we were reaching out to everybody to give the pitch.
BY MR. STEWART:
Q. I'm going to hand you a document marked Exhibit 55.
(Whereupon, Purdue-Wright-55 was marked for identification.)
A. Mm-hmm.
BY MR. STEWART:
Q. And I'll just tell you, I don't think you've seen this exhibit, it is an excerpt from

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a deposition of Richard Sackler. Could you turn to Page 112, which is the second page in the exhibit which is Exhibit 55?
A. Mm-hmm.
Q. And do you see that there's a question is asked, okay, about Curtis Wright, and the question is asked, "And at that time he was the person who was reviewing your-all's OxyContin submission to the FDA?"
Do you see that?
A. Mm-hmm.
Q. Do you see that Richard Sackler's answer is "He was the medical reviewer, that's correct."
Do you see that?
A. Mm-hmm.
Q. And that's accurate, you were the medical reviewer for the OxyContin?
A. I was one of the medical reviewers.
Q. So you were a medical reviewer for OxyContin, fair? Mr. Sackler's description is correct?
A. Yes.
Q. And then the question is, "And he's the guy that actually approved it to be sold,

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you know, allowed you-all to" take it -- "sell it from the FDA?" And Richard Sackler says "That's my recollection."

Do you see that?

MR. PETRILLO: I think you misread it, but pretty close.

BY MR. STEWART:

Q. Why don't I read it again. Strike that. Here's what I'm reading.

"Question: And he's the guy" -- parenthetically referring to you -- "that actually approved it to be sold, you know, allowed you-all to sell it from the FDA?"

Do you see that question?

A. I see that question.

Q. And Dr. Sackler says "That's my recollection."

Do you see that?

A. Mm-hmm.

Q. Now, the next question is -- and by the way, Dr. Sackler's recollection is accurate, is that fair?

A. So far.

Q. Do you see the next question is "You-all ultimately hired him a few years later,

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didn't you?" And Dr. Sackler's answer is, "We did hire him, but not after his tenure at the FDA. We -- he spoke to somebody at Purdue when he was planning on leaving the FDA, and Paul and I discussed it and agreed that we should not hire somebody who had -- who had reviewed our product and had left. And so he went to another company, regrettably for us, because he was very, very knowledgeable."

Do you see that?

A. Yes.

Q. Now, do you see that Dr. Sackler's testifying that you did contact Purdue while you were at the FDA.

Do you see that?

A. Yes.

MR. SNAPP: Object to the form.

BY MR. STEWART:

Q. Can you explain that?

MR. SNAPP: Object to the form.

A. He's wrong. He's just wrong.

BY MR. STEWART:

Q. So in your dealings with Dr. Sackler, this is the first instance you can recall when he's made an inaccurate statement, in your view?

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MR. SNAPP: Object to the form.

A. I didn't say that. I hadn't -- I wasn't monitoring my boss for the accuracy of his comments.

BY MR. STEWART:

Q. I guess I'm saying, all the other times, you can't remember him making another inaccurate statement, can you, in your dealings with him at Purdue?

MR. SNAPP: Object to the form.

A. I didn't have enough dealings with him to know.

BY MR. STEWART:

Q. Well, in the limited dealings you had, and we went through a series of e-mails, he never made a statement to you that was inaccurate, fair?

A. That's true.

Q. But you're saying in this case when he says that you called Purdue when you were planning on leaving the FDA, you think that is an inaccurate statement?

A. That is inaccurate.

Q. And we would just have to get Dr. Sackler on the stand and figure out how to

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untangle this inaccuracy, fair?

MR. PETRILLO: Objection.

MR. SNAPP: Object to the form.

BY MR. STEWART:

Q. Is that correct?

A. I don't know what you would have to do. I don't know why you would want to do it. But I can assure you I was recruited by the president of Adolor out of the agency, and I, up to the point where he started talking to me, I had not really had plans to leave the agency.

Q. Did you ever ask the president of Adolor "who owns this company?"

A. No.

MR. STEWART: Let's take a break and then we'll come back and finish up.

THE VIDEOGRAPHER: We are now going off the record, and the time is 6:35 p.m.

(Whereupon, a recess was taken.)

THE VIDEOGRAPHER: We are now going back on the record, and the time is 6:42 p.m.

MR. STEWART: Dr. Wright, I'm told we're effectively out of time, so thank you. And I'm going to keep the deposition open, but of course, subject to the agreement that I

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announced with counsel earlier, and that's -- I'm done with my questions today.
MR. SNAPP: I have no questions.
MS. SINGER: I have just a few. I can't. Never mind. There was one document that we needed to just clear up because we gave you all pieces of it.
MR. PETRILLO: Do you want to put that on the record, do you have a clean one?
MR. SNAPP: Do you want to just substitute in a clean one?
MS. SINGER: Yeah, I mean, I'd love to be able to ask the one question about the page we didn't have, but I'm at your mercy on that.
MR. SNAPP: Can we go off the record?
THE VIDEOGRAPHER: We are now going off the record, and the time is 6:43 p.m.
(Whereupon, a recess was taken.)
THE VIDEOGRAPHER: We are now going back on the record, and the time is 6:46 a.m.

FURTHER EXAMINATION

BY MS. SINGER:

Q. All right. Dr. Wright, I'm reshowing you Exhibit 31, we had a missing pages issue earlier in your deposition, so could you take a

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look and confirm that this is an Integrated Summary of Safety that you saw earlier with all of the pages there?
(Witness reviewing document.)
A. Yeah, it is.
Q. And I want to direct your attention to Bates number 040. In the interest of time I will read you the section under "ADE Conclusion." "The trial data set does not support a definite conclusion that the CR form has fewer adverse events than the IR form in the intended population of use. There is a thin but possible trend toward a lower frequency of opioid adverse effects for CR in patients not tolerant of opioids suggested by the PK data in normal volunteers."
Have I read that accurately?
A. You have read that accurately.
Q. And does that refresh your recollection as to when OxyContin had a better safety profile than other opioids, than IR opioids?
MR. SNAPP: Object to the form.
A. I would characterize that as a hint, but not proof.

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MS. SINGER: Okay. One question. Off the record.
THE VIDEOGRAPHER: Okay. Conclude?
MS. SINGER: Conclude.
THE VIDEOGRAPHER: We are now going off the record, and the time is 6:48 p.m.
(Whereupon, the deposition was concluded.)

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C E R T I F I C A T E

I, MAUREEN O'CONNOR POLLARD, LSR #473, RMR, CLR, and Notary Public,do hereby certify that there came before me on the 19th day of December, 2018, the person hereinbefore named, who was duly sworn to testify to the truth of their knowledge concerning the matters in this cause, and their examination reduced to typewriting under my direction and is a true record of the testimony.

I further certify that I am neither attorney for or related or employed by any of the parties to the action, and that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.
In witness whereof, I have hereunto set my hand and seal this 24th day of December, 2018.

_____
MAUREEN O'CONNOR POLLARD, License #473
Realtime Systems Administrator, RMR
Notary Commission Expires: 10/31/2022

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Please read your deposition over carefully and make any necessary corrections. You should state the reason in the appropriate space on the errata sheet for any corrections that are made.

After doing so, please sign the errata sheet and date it. It will be attached to your deposition.

It is imperative that you return the original errata sheet to the deposing attorney within thirty (30) days of receipt of the deposition transcript by you. If you fail to do so, the deposition transcript may be deemed to be accurate and may be used in court.



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ACKNOWLEDGMENT OF DEPONENT

I, _____, do Hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

_____

WITNESS NAME DATE

Subscribed and sworn
To before me this
_____ day of _____, 20____.
My commission expires: _____

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Notary Public



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